SAN FRANCISCO HEALTH PLAN
Here for you

Joint Meeting of the San Francisco Health Authority and the San Francisco Community Health Authority

Governing Board Agenda
Wednesday, November 2, 2016 12 pm-2 pm
50 Beale St., 13th Floor
San Francisco, CA 94105

**********OPEN SESSION **********

Public Comment on any matters within SFHA/SFCHA purview

1. (V) Approval of Consent Calendar
   a. Minutes from September 7, 2016 Meeting
   b. Minutes from Quality Improvement Committee (QIC) Meeting
   c. Credentialing and Recredentialing Recommendations
2. (V) Review and Approval of the Annual Independent Audit Report for FY 2015-16 (Moss Adams, LLP)
3. (V) Review and Approval of Unaudited Monthly Financial Statements and Investment Reports (John A. Gregoire and Reece Fawley)
4. Chief Medical Officer's Report (James Glauber, MD, MPH)
   (V) a. Review and Approval of Proposal to Rollover 2013 Practice Improvement Program (PIP) Funds
   (V) b. Review and Approval of PIP CY 2017 Funding
   (D) c. HEDIS and CAHPS Results Report
   (D) d. Beacon Health Options and Adult Non-Specialty Mental Health Utilization Update
   (D) e. Access to Care Dashboard
5. (D) Discussion of Five-Year Hepatitis C Utilization Projections (Lisa Ghotbi, Pharm.D. and John A. Gregoire)
6. (D) Member Advisory Committee Report (Maria Luz Torre & Irene Conway)

**********CLOSED SESSION **********

7. Finance Committee Report
   (V) Review and Approval of Medi-Cal Rates Effective January 1, 2017 (John F. Grgurina, Jr.)
   Pursuant to Welfare and Institutions Code Section 14087.36(y)

**********OPEN SESSION **********

8. (D) Chair's Report on Closed Session Items (Barbara Garcia, MPA)

9. (D) CEO Report (John F. Grgurina, Jr.) - Highlighted Items – Health Homes, Operational Updates, Pharmacy Benefit Management Contract Extension, and Business Continuity Plan Update

The San Francisco Health Authority and San Francisco Community Health Authority will meet concurrently.

(V) Denotes an Action Item Requiring A Vote ***(D) Denotes A Discussion Item***

Next meeting: January 4, 2017
12:00 pm to 2:00 pm

Please Note These Upcoming SFHA/SFCHA Meetings:

- Member Advisory Committee: November 4, 2016 (1:00 pm-3:00 pm)
- Member Advisory Committee: December 2, 2016 (1:00 pm-3:00 pm)
- Quality Improvement Committee: December 8, 2016 (7:30 am-9:00 am)
- Finance Committee: January 4, 2017 (11:00 am-12:00 pm)
- Governing Board: January 4, 2017 (12:00 pm-2:00 pm)

Public Comment: Members of the public are welcome to address the Governing Board on any item on the public meeting agenda. Please limit your comments to 3 minutes and to the specific subject under discussion. All meetings are wheelchair accessible. When attending these meetings, please accommodate persons with severe allergies, multiple chemical sensitivity and/or related disabilities by not wearing perfume.

If you plan to attend, please contact Valerie Huggins at (415) 615-4235. We must provide all visitors' names to the Building Security in advance of the meeting.

Agenda Item 1:

Action Item

Approval of Consent Calendar:

a. Minutes from September 7, 2016 Meeting
b. Quality Improvement Committee (QIC) Minutes
c. Credentialing and Recredentialing Recommendations

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P.O. Box 194247
San Francisco, CA 94119

MEMO

Date: October 25, 2016

To	**SFHP Governing Board**
From	**John F. Grgurina, Jr.**
Regarding	**Consent Calendar Items for Approval**

Consent Calendar
All matters listed hereunder constitute a Consent Calendar and are considered to be routine by the Governing Board of the San Francisco Health Authority and San Francisco Community Health Authority Board and will be acted upon by a single vote of the Board. There will be no separate discussion of these items unless a member of the Board so requests, in which event the matter shall be removed from the Consent Calendar and considered as a separate item.

Item 1a. Recommendation to Approve Board Minutes
It is recommended that the Governing Board approve the minutes from the Governing Board meeting held on September 7, 2016. The minutes are attached for review.

Item 1b. Recommendation of the Quality Improvement Committee (QIC) Minutes
It is recommended that the Governing Board approve the attached minutes from the August 2016 QIC meeting, as recommended by the QIC.

Item 1c. Recommendation of Credentialed and Recredentialed Providers
It is recommended that the Governing Board approve the attached list of providers that have been approved for credentialing and recredentialing by the Physician Advisory and Peer Review Committee.

Agenda Item 1:

Action Item

Approval of Consent Calendar:

a. Minutes from September 7, 2016 Meeting

SAN FRANCISCO HEALTH PLAN™

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Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
September 7, 2016
Meeting Minutes

Chair:	Steven Fugaro, MD (Chair)
Vice-Chair:	Barbara Garcia
Secretary-Treasurer:	Reece Fawley

Members Present: Dale Butler , Eddie Chan, Pharm.D., Lawrence Cheung, MD, Irene Conway, Reece Fawley, Steven Fugaro, MD, Barbara Garcia, John Gressman, Roland Pickens, Mara Luz Torre, Emily Webb, David Woods, and Brenda Yee

Members Absent: Edwin Batongbacal and Steve Fields

Steven Fugaro, MD, chaired the meeting and called the meeting to order. Dr. Fugaro asked if there was anyone from the public in attendance that wanted to make any comments. There was no one in attendance.

1. Approval of Consent Calendar

The following Board items were on the consent calendar for the Board's approval:

a. Review and Approval of Minutes from June 8, 2016 Governing Board Meeting
b. Quality improvement Committee (QIC) Minutes
c. Amendment to Quality Improvement Program Evaluation
d. Credentialing and Recredentialing Recommendations
e. Appointment to Pharmacy and Therapeutics Committee

The Board unanimously approved the consent calendar without any issues.

2. General Overview of Medicare Dual Eligible-Special Needs Plan

Gorman Health Group Consultants attended the Governing Board meeting to present an overview of Medicare Advantage plans and Dual Eligible Special Needs plans.

John F. Grgurina, Jr., CEO, mentioned at the last Board meeting the Plan brought a proposal to look at Medicare Dual Eligible- Special Needs Plan Program and looking at the possibility to participate as a D-SNP in 2018 or 2019 and will come back to the Board in a future meeting, after the completion of Phase 2 of the analysis by Gorman.

Charro Knight- Lilly, Senior Vice President, Gorman Health Group, presented a general overview of Medicare Dual Eligible-Special Needs Plan. (Detailed PowerPoint presentation was provided in the Board packet.)

3. Approval of Year-End FY 2015-16 and Year-to-Date July 2016 Unaudited Financial Statements and investment Income Reports

Recommendation: Review and approve the year-end financial statements for the Fiscal Year (FY) 2015-16.

John Gregoire, CFO, presented the unaudited financial statements for the year-end of FY 2015-16. (The narrative summary and financial documents were provided to the Finance Committee and are incorporated by reference.)

The year ending June 30, 2016 shows a year-to-date positive margin of $29.9 million (which is $9.5 million greater than budget) and a positive margin of $319,000 for the month of June. The main driver for the lower than expected monthly surplus is the recording of an extra $895,000 in administrative expenses due to project close-outs as well as leaving the month open longer into July to ensure the capture of all FY15-16 expenses in the fiscal year.

Other significant events recorded during June 2016 include:

- Capitation and fee-for-service rate increases ranging from 3.4% to 8.6% (average of 5.7%) implemented 1/1/2016.
- $291,000 in additional Medi-Cal revenue due to 117 maternity events (budget included 80 events).
- $338,000 in pharmacy and non-specialty mental health third-party administration services recorded in administrative expenses.
- $90,000 in CalPERS pension expense related to GASB 68 requirements.

	PROFIT/LOSS					
	JUN 2016					
	MONTH			YTD		
	ACTUAL	BUDGET	FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)
FROM OPERATIONS (LOSS)	$ 111,284	$ 1,712,265	$ (1,600,981)	$ 29,091,119	$ 20,028,864	$ 9,062,255
INTEREST/INVESTMENT CHANGE	$ 207,591	$ 33,333	$ 174,258	$ 805,530	$ 400,000	$ 405,530
NET SURPLUS (LOSS)	$ 318,875	$ 1,745,598	$ (1,426,723)	$ 29,896,649	$ 20,428,864	$ 9,467,785

Overall premium revenue came in at $50,014,000 versus a budget of $45,801,000. The Medi-Cal Expansion category contributed $22,895,000 in revenue, which is $1,414,000 above budget. On a year-to-date (YTD) basis, total SFHP member months exceed the budget by 71,732. This translates to an additional $30,005,000 in premium revenue.

Additional membership highlights for June versus budget expectations:

- 5,801 **more** member months overall:
- 9,386 **more** Medi-Cal Expansion member months
- 1,979 **fewer** Medi-Cal non-SPD member months
- 622 **fewer** Aged and Disabled (SPDs) member months

- 889 **fewer** Healthy Workers member months
- 95 **fewer** Healthy Kids member months

With the Finance Committee recommendation, the Board unanimously approved the Year-End FY 2015-16 unaudited financial statements as presented.

Recommendation: Review and approve the YTD July 2016 unaudited financial statements and investment income reports.

John Gregoire, CFO, presented the YTD unaudited financial statements for the period ending July 2016. (The narrative summary and financial documents were provided to the Finance Committee and are incorporated by reference.)

July 2016 shows an overall surplus of $1,105,000 which is $480,000 below budget:

- $560,000 increase to the Incurred But Not Reported (IBNR) claims reserve.
- $684,000 decrease in Medi-Cal Non-SPD revenue due to 4,272 fewer member months.
- $218,000 increase in Medi-Cal Adult Expansion (MCE) revenue due to 604 more member months.

Other significant events recorded during July 2016 include:

- 8% capitation rate reduction for the Medi-Cal Adult Expansion (MCE) category effective July 2016.
- $4,079,000 reduction in SPD and MCE revenue due to a sharp decrease in Hepatitis C treatment weeks. This revenue loss was offset by a $4,177,000 reduction in Pharmacy expense.

	PROFIT/LOSS					
	JUL 2016					
	MONTH			YTD		
	ACTUAL	BUDGET	FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)
FROM OPERATIONS (LOSS)	$ 1,064,313	$ 1,527,790	$ (463,477)	$ 1,064,313	$ 1,527,790	$ (463,477)
INTEREST/INVESTMENT CHANGE	$ 41,042	$ 58,000	$ (16,958)	$ 41,042	$ 58,000	$ (16,958)
NET SURPLUS (LOSS)	$ 1,105,355	$ 1,585,790	$ (480,435)	$ 1,105,355	$ 1,585,790	$ (480,435)

With the Finance Committee recommendation, the Board unanimously approved the YTD unaudited financial statements and investment reports for the period ending July 31, 2016, as presented.

The Governing Board adjourned to Closed Session.

4. Review and Approval of Network Expansion for New Provider Contract with Jade Medical Group

This item was discussed in closed session.

5. Update on Department of Health Care Services Notice of Dispute

This item was discussed in closed session.

6. Review and Approval of Annual Performance Evaluation of CEO

This item was discussed in closed session.

The Governing Board resumed in Open Session.

7. Report on Closed Session Action Items

Steven Fugaro, MD, reported that the Board approved the following action items:

a. Approved the CEO to contract with the Jade Medical Group, with similar terms as SFHP's other medical groups.
b. Approved the CEO's Annual Performance Evaluation with a rating of Exemplary/Outstanding and a public announcement of the CEO's salary.
c. Approved addition of three additional days of paid time off for SFHP staff.

8. Review and Approval of Organizational Score and SFHP FY 15-16 Year-End Staff Bonus

Recommendation: San Francisco Health Plan (SFHP) finished FY15-16 successfully by achieving a score of 97.5% for the success criteria approved by the Governing Board. It is recommended that the Governing Board consider approval of the following items:

1) With the FY15-16 financial position meeting the sufficient requirement to pay the staff bonus and bonus funds were budgeted in the year-end statements, approval of distribution of staff bonuses, according to the organizational score and individual performance.
2) Approval of organizational score for performance against goals of 97.5% (Detailed memo was provided in the Board packet).

John F. Grgurina, Jr., CEO, reviewed the background of the success criteria with the Board. The following table summarizes the Governing Board-approved goals and success criteria and results for FY15-16:

Goal and Success Criteria	Possible Points	Score
Goal 1: Access to Care SFHP shall establish an access improvement strategy that includes an Access to Care Committee to oversee the monitoring of access and the development of provider interventions, to ensure network compliance with timely access requirements, and to implement corrective actions, either directly as a Committee or through designated subgroups.		
CAHPS Access Domain Improvement Improvement in two Access Domains from 2015 Baseline results (available June 2015 and weighted by membership) • Stretch: 3% (5 points; each 2.5 points) • Meets: 2% (4 points; each 2 points) • Minimum: 1% (3 points; each 1.5 points)	5	**2.5**

Goal and Success Criteria	Possible Points	Score
Result: Achieved 3% improvement in the Access Domain for Getting Needed Care – 2.5 points Did not achieve at least 1% improvement in the Access Domain for Getting Care Question (results were invalid due to invalid sample size) – 0 points **Total Score : 2.5 points**		
Accomplishment of Project Work Plan Milestones for Access • Stretch: 100% (10 points) • Meets: 90-99% (9 points) • Min: 80-89% (8 points) **Result:** Achieved 100% completion of access initiatives project work plan. The "Stretch" goal was met for a score of 10 points.	10	**10**
Goal 2: NCQA Accreditation Strengthen our ability to serve our members and providers through achieving NCQA Interim Medicaid accreditation status by July 2016. **Result:** Achieved NCQA Interim Medicaid accreditation in June 2016, with a score of 49.18 points out of 50 points. By achieving accreditation, the total points for Goal 2 is 15 points. This was a pass/fail score.	15	**15**

Goal and Success Criteria	Possible Points	Score
Goal 3: Comply with requirements mandated by state legislation, regulations, program contracts and grant agreements. In FY 2015-16, SFHP will have at least 40 projects related to rate changes, DHCS and DMHC projects, legislative mandates and grant requirements. The list of these mandates will continue to expand and change throughout the year. The following are some of the larger projects: • Encounter data modernization • Medi-Cal Rate Changes and Pass-throughs • State ad hoc reports, e.g., mental health utilization • DHCS and DMHC corrective actions related to audit reports • Legislative mandates • Grant and Program Mandates (Healthy Kids, Healthy Workers, HSF) **Stretch:** 90% or more of projects' deadlines or success criteria are met - 70 pts **Meets:** 85-89.9% of deadlines or success criteria are met- 60 to 69 pts **Minimum:** 80-84.9% of deadlines or success criteria are met - 50 to 59 pts **Result:** Of the initial 40 projects presented to the Board in May 2015, 14 were determined to be operational in nature rather than mandates. Of the remaining 26 projects, 16 projects' scores were used in the calculation of the score for the bonus. The other ten projects were completed on time, but were not included in the score for the bonus because the scale of the project was not as significant as the other 16 projects. The major 16 projects were organization-wide, involving significant work by more than three departments. The other ten projects were completed with less than three departments. The total score for all 26 mandated projects is 99.60. The total score for the 16 major mandated projects for use in the calculation of the organization score is 99.38. With a score of 99.38, the Stretch goal was met, for a total score of 70 points for Goal 3. Detailed description of these projects is attached.	70	**70**
Total	100	**97.5**

Based on these results, Mr. Grgurina recommended the following for Board approval:

1) FY 15-16 financial position met the sufficient requirement to pay the staff bonuses that were budgeted for FY15-16.
2) Distribution of staff bonuses, according to the organizational score of 97.5% and individual and department performances.

The individual employee goals achievement, department score and organization score are used to determine the employee's bonus payment, if any, with the following weights:

Weights	Executives	Directors	Managers	Staff- Individual Contributors
Organization score	50%	40%	34%	25%
Department score	25%	35%	33%	25%
Individual Goals score:	25%	25%	33%	50%
Total	100%	100%	100%	100%

With the Finance Committee recommendation to the pay the bonus, the Board unanimously approved the Organizational Score and SFHP FY 15-16 Year-End Staff Bonus, in addition to this, due to the extraordinary success of FY15-16, the Board approved a one-time addition of three days of paid time off bonus.

9. Review and Approval of Specific Measurements for FY 16-17 Organizational Access Goal Measure

Recommendation: San Francisco Health Plan (SFHP) recommends the approval of specific measures for the FY16-17 organizational goal for access.

<u>Access Measures</u>

One of SFHP's three FY16-17 organizational goals is focused on improving member's access to health care services. The access measurements are defined as follows.

1) CAHPS Access Domain Improvement – **10 pts**
   One of our goals in this area will be to achieve improvement in the access domain of the Consumer Assessment of Health Plans Survey (CAHPS) from the 2016 baseline results. The following will be the targets for improving our CAHPS scores in two Access Domains:

Access Domain #1: Getting Care Quickly (2016 Score- 65%)

- Stretch: Improve access domain by 3% - 5 points
- Meets: Improve access domain by 2% - 4 points
- Minimum: Improve access domain by 1% - 3 points

Access Domain #2: Getting Needed Care (2016 Score- 66%)

- Stretch: Improve access domain by 3% - 5 points
- Meets: Improve access domain by 2% - 4 points

- Minimum: Improve access domain by 1% - 3 points

There are two questions in each Access Domain. The domain score is the average of those two questions. To be included in the average, there must be at least 75 respondents to each question. Otherwise, if there are insufficient responses to a question, that question will be removed from the domain score.

2) Access-Related Activities Work Plan - **15 points**
For the second access-related goal, we established the following access monitoring and improvement projects for FY16-17:

a. Implement telemedicine to expand network of services for members.
Implement telemedicine program by the agreed upon timeline or within two months of regulatory approval, if approval is received later than the original timeline. **6 points, pass or fail**

b. Increase the adult non-specialty mental health penetration rate from the baseline measure of 1.28%, measured from 4/1/2016 to March 31, 2017 (Medi-Cal non-dual members only) - **6 points**
Stretch – Increase penetration to 3% – **6 points**
Meet – Increase penetration to 2.5% – **4 points**
Minimum – Increase penetration to 2.0% -**2 points**

c. Focused Activities Monitor and Improve Access – **3 points**
- Develop benchmark and determine best practices for high-performing Medicaid managed care plans on CAHPS access -**1.5 points, pass or fail**
- Develop and implement three actionable measures for the access dashboard - **1.5 points, pass or fail**

SFHP's two other organizational goals for FY16-17, for a total of 100 points for all three goals, are 1) passing the mock survey for 1st Year NCQA Medicaid Accreditation for 25 points, pass or fail; and 2) Process Improvement Projects – Six projects for total of 50 points. We will provide the Board with the detailed measurements for the six projects at the November Board meeting.

Please see the attached visual representation of the FY16-17 Organizational Goals and Success Criteria with the proposed access measures.

We recommend the Governing Board approve these specific measures for the FY16-17 organizational goal focused on access.

The Board unanimously approved the specific measures for the FY16-17 organizational goal for access with the exception of item 2.b to increase the stretch goal to 3.5% from 3.0%.

10. Review and Approval of a Proposal for an SFHP Community Partner Grant
Recommendation: SFHP recommends the approval a Community Partner Grant of $30,000 to the San Francisco-Marin Food Bank.

Background

The San Francisco-Marin Food Bank (Food Bank) has been in existence for over 27 years with a mission to end hunger in San Francisco and Marin. In 2016 the Food Bank anticipates it will:

- Serve 225,000 people through its programs.
- Deliver 47 million pounds of food through San Francisco and Marin, with more than half being fresh produce.
- Distribute 100,000 meals worth of food each day.
- Provide 30,000 families with food from pantries each week.
- Provide 9,000 children with daily morning snacks each school day.

In addition, SFHP has worked directly with the Food Bank and has identified the organization as one that has a positive impact on our members. Although we do not have specific statistics, we believe many of the families receiving meals, school or daycare morning snacks, or food from the pantries likely include our SFHP members. Additionally, the Food Bank was a key partner in SFHP's City-Wide Enrollment Event in January 2016. The Food Bank provided 100 bags of groceries for our members and applicants that attended the event.

Lastly, our staff and their family members, for a total of over 40 individuals, recently volunteered at the Food Bank on Saturday, July 18th, for a positive experience for our employees. We have selected the Food Bank as our one charitable organization that our staff will donate their time to improve the lives of our members in San Francisco. We will continue to organize volunteer events at the Food Bank for our staff.

Please note that at this time we have determined that no Executive staff members have any direct or indirect financial interest in the San Francisco-Marin Food Bank. The donation therefore is not expected to create a conflict of interest for SFHP.

While this is a one-time donation to the Food Bank, we plan to include an item in the FY17-18 budget that will include criteria for charitable giving for review and approval by the Finance Committee and Governing Board during the budget approval process for the next fiscal year.

We recommend that the Finance Committee and Governing Board approve a one-time donation of $30,000 to the San Francisco-Marin Food Bank.

With the Finance Committee recommendation, the Governing Board unanimously approved a one-time donation of $30,000 to the San Francisco-Marin Food Bank.

11. Member Advisory Committee Report

Maria Luz Torre and Irene Conway briefly reported that SFHP staff members attended the Members Advisory Committee meeting to discuss customer service and grievances and answered most of their questions.

12. Chief Medical Officer's (CMO) Report

Due to time constraint this item was not discussed and will be presented at the November Board meeting.

13. Five-Year Utilization Projections of Hepatitis C Treatments

Due to time constraint this item was not discussed and will be presented at the November Board meeting.

14. CEO Report

Due to time constraints the CEO report was not discussed. (The September 2016 CEO Report is incorporated as a reference document in the Board packet.)

15. Adjourn

The meeting was adjourned.

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Reece Fawley, Secretary

San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
June 8, 2016
Closed Session Minutes

1. Review and Approval of Network Expansion for New Provider Contract with Jade Medical Group

Recommendation: SFHP recommended that the Finance Committee and Governing Board approve the CEO to contract with Jade Medical Group with 1) parameters for rates similar to existing medical groups, i.e., acceptance of the rates that SFHP pays its other network providers; 2) assurance of network adequacy, i.e., that the new network is appropriately credentialed for all necessary physician specialties and hospital services; and 3) assurance from Chinese Hospital Association (CHA) and from Chinese Community Health Care Association (CCHCA) that the existing CCHCA/CHA network for SFHP members remains intact until both Jade Medical Group and Asian American Medical Group (AAMG) have successfully implemented new networks and contracted with SFHP.

Deena Louie, Chief Operations Officer, reviewed the background to the Finance Committee. Chinese Hospital Association (CHA) has formed a new medical group called Jade Medical Group. This group is comprised of physicians and extenders who staff the CHA Clinics as well as some independent practice physicians.

Jade Medical Group recently filed with the Department of Managed Healthcare (DMHC) and was approved to be a risk-bearing organization (RBO), which means they can accept risk arrangements. The partner hospital for Jade Medical Group is the Chinese Hospital. Jade Medical Group must ensure, as part of their agreement with SFHP, to provide services in all specialties required by the DMHC.

CHA has requested that we contract with Jade Medical Group to provide services to SFHP members. We are currently in negotiations for a capitation risk agreement with the medical group for rates that are the same as rates with other network providers. It will take approximately six months for SFHP to implement the new medical group. Once DMHC approval is received and Jade Medical Group meets the plan's requirements for delegation of administrative functions, SFHP will transfer CHA Clinic members from CCHCA to Jade Medical Group, since the CHA primary care providers (PCPs) will no longer belong to CCHCA. This will ensure the members have continuity of care with their PCPs, who will then be part of Jade Medical Group. The Jade Medical Group would also accept new members based on choice, or as part of our regular default assignment algorithm.

CCHCA, in the meantime, has also formed a new medical group called Asian American Medical Group (AAMG) and is working to build a full-service network. Once they build a full network, including a hospital affiliation, SFHP would negotiate to add this new AAMG network to the SFHP provider network.

SFHP's primary goal is to provide our members with access to quality care. In order to minimize disruption of our members' care, SFHP has been working with both provider partners to ensure that our members are minimally affected. Members should not lose

their PCP, assuming that both Jade and AAMG remain committed to minimal disruption to our members. A termination of the existing CCHCA/CHA network before both AAMG and Jade networks are functional could create significant member disruption.

SFHP will incur costs such as re-issuing SFHP member ID cards and re-formatting the provider directory that are associated with such network changes. Additionally we anticipate some member confusion as these two networks become operational, which will likely lead to longer phone calls in Customer Service. We anticipate there may also be some provider confusion about the new medical group, resulting in potential inappropriate and inadvertent referrals that would be considered out-of-medical-group services to the new medical group.

SFHP recommended Board approval for the CEO to contract with Jade Medical Group with 1) the same payment and rates as SFHP's other medical groups; 2) assurance of network adequacy, i.e., that the new network is appropriately credentialed for all physician specialties and hospital services; and 3) with assurance from both CHA and CCHCA that the existing CCHCA/CHA network for SFHP members will remain intact until both Jade Medical Group and AAMG have successfully implemented new networks and contracted with SFHP.

The contract may be signed before the next Board meeting in November.

Two Board members, Brenda Yee and Dr. Lawrence Cheung, abstained from the vote. With the Finance Committee recommendations, the Board unanimously approved the proposal for the CEO to contract with Jade Medical Group with 1) the same parameters for payments and rates, i.e., acceptance of the rates that SFHP pays its other network providers; 2) assurance of network adequacy, i.e., that the new network is appropriately credentialed for all necessary physician specialties and hospital services; and 3) assurance from Chinese Hospital Association (CHA) and from CCHCA that the existing CCHCA/CHA network for SFHP members remains intact until both Jade Medical Group and AAMG have successfully implemented new networks and contracted with SFHP. In addition, based on the recommendation from the Finance Committee, the Board also voted to have SFHP review all communication between Jade Medical Group and SFHP members to avoid confusion among SFHP members.

2. Update on Department of Health Care Services (DHCS) of Dispute

The following was provided to the SFHP Finance Committee and Governing Board for information only. No action was required.

John F. Grgurina Jr., CEO, gave a brief background and update. At the June 2016 meetings, the Finance Committee and Governing Board approved the CEO to negotiate dropping the two Notice of Disputes (FY 03-04 rate dispute and FY 10-11 retroactive rate cut) with the DHCS in exchange for SFHP to be paid the 25% upper rate range payments for Medi-Cal expansion in FY 16-17 and FY 17-18.

Since the June 2016 meeting, the CEO has worked with SFHP's external counsel to notify the appropriate administrative law judges, who were assigned to the two appeal cases, of SFHP's decision to dismiss the appeal cases. Additionally, the SFHP CEO informed the Director, DHCS and the Chief Deputy Director, Health Care Programs, DHCS, about the decision to dismiss the appeal cases in return for access to the 25%

upper payment range. Letters to the administrative law judges were included in the Board packet.

3. Review and Approval of Annual Performance Evaluation of CEO

The Governing Board approved the Personnel Committee's recommendations for the CEO's annual performance evaluation with a rating of Exemplary/Outstanding and an annual compensation of $392,731. The Governing Board also approved the Personnel Committee's recommendation of separating the CEO from the Executive Team in the 401(a) pension plan. As part of SFHP's 401(a) pension plan, all Executives including the CEO, must contribute the maximum employee elective deferral amount (currently $18,000) in order to receive the SFHP employer 5% contribution. All Executives agreed to this back in 2013 when the plan was created. However, there was not unanimous agreement to also contribute the maximum over age 50 catch up deferral (currently $6,000). Our administrator of the 401(a), IMCA-RC, informed SFHP Human Resources that we can remove the CEO from the Executives as a separate classification and allow the CEO to contribute the maximum age 50 catch up. This will not add any additional costs to SFHP.

Agenda Item 1:

Action Item

Approval of Consent Calendar:

b. Quality Improvement Committee (QIC) Minutes

SAN FRANCISCO HEALTH PLAN™

Here for you

Quality Improvement Committee Minutes

Date: August 14, 2016

Meeting Place: San Francisco Health Plan, 50 Beale Street 12th floor, San Francisco, CA 94105

Meeting Time: 7:30-9:00 am

Present: Ellen Chen, MD; Irene Conway; Edward Evans; Todd May, MD; Dennis McIntyre, MD; Kenneth Tai, MD; Ana Valdes, MD; Joseph Woo, MD

Staff Present: James A. Glauber, MD; Fiona Donald, MD; Cassie Caravello; Ellie Pringle; Elizabeth Sekera; Adam Sharma; Jim Soos; Jess Strange; Gabrielle Torres; Nicole A. Ylagan

Topic	Discussion [including Identification of Quality Issue]	Follow-up [if Quality Issue identified, Include Corrective Action]	Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution]
Call to Order	• Meeting was called to order at 7:30 am. • No public comments or questions.	• No follow up needed	• n/a
Follow Up Items	<u>NCQA</u> • Dr. Glauber informed QIC that SFHP received Interim Accreditation status with National Committee on Quality Assurance (NCQA). • SFHP received over 49 points out of a possible 50 points. • First full survey Accreditation will include HEDIS and CAHPs data (50% of total score).	• Dr. Donald to send out link for Health Homes	• Dr. Donald to send out link for Health Homes

	<u>Provider Appointment Availability Survey (PAAS)</u> • Dr. Glauber reminded committee members that the 2nd round of PAAS will be conducted from 8/22/16 – 12/16/16. • He asked the committee to remind clinics that the survey will be completed and that a response for the survey should be completed within 48 hours. • Last year, the compliance rate was low because many clinics did not respond within 48 hours. <u>Follow-up Item:</u> • Dr. Donald indicated currently there are no consolidated publications on Health Homes. • She can send out a link on the publications that she has.		
Consent Calendar	• Review of QIC Minutes – June 9, 2016 • Membership Report • Update of Pharmacy & Therapeutics Committee Membership & Minutes New formulary criteria for Hepatitis C medications. Dr. Glauber highlighted this section because of the new criteria for Epclusa, which allows the treatment for all 6 genotypes. This medication is lower in cost compared to Harvoni. o Also, Methadone was taken off SFHP's formulary.	•	• Approved: o Review of QIC Minutes – June 9, 2016 o Membership Report o Update of Pharmacy & Therapeutics Committee Membership & Minutes o Dr. Nicholas Jew, new P&T Member o UM Committee Minutes ▪ June 2016 ▪ July 2016

	• Nicholas Jew, MD, new P&T Member • UM Committee Minutes o June 2016 o July 2016 All items in Consent Calendar approved unanimously.		
Quality Monitoring	<u>HEDIS Results ResultsYear2016 (Measurement Year 2015)</u> Cassie Caravello, Program Manager of Population Health and Elizabeth Sekera, Lead HEDIS RN, presented the HEDIS Results for RY 2016. • SFHP had 13 measures in the 90th percentile. • SFHP ranked 3rd highest Medicaid plan in CA for RY 2015. • 50% of the Auto Assignment measures were in the 90th percentile. • HbA1c, Prenatal Care, Well Child visits, Medication Management for People with Asthma and Use of Imaging Studies for Low Back Pain were in the 75th percentile. o SFHP's Clinical Oversight Committee will prioritize 5 measures for improvement • SFHP has 8 memberincentive programs to improve HEDIS compliance rates. • RY2016, SFHP made the Diabetes Incentive into two separate programs which contributed to the high participation/compliance rate: 1)HbA1c testing/blood pressure		

	control/medical attention for nephropathy 2) Retinal Eye exam • Incentives forthe Disease Management (DM) Program, which targets members with asthma and diabetes, are aligned with HEDIS comprehensive diabetes control measures. • SFHP contracted with CareNet to make assessment calls and provide information to qualifying members about the DM program. • Participants in the Practice Improvement Program (PIP) have the opportunity to improve in 5 priority measures. • Health Outcomes Improvement plans to focus on data quality, with block funding as a key strategy • New committee structures o Clinical Oversight Committee – help prioritize HEDIS measures and focus on improvements o Interventions Committee – interdisciplinary team to help operationalize interventions • NCQA 1st Survey Accreditation will require 30 additional HEDIS & CAHPS measures Question Ed Evans from Member Advisor Committee (MAC): Can there be an incentive program for adolescents? Response: Currently, there isn't an incentive		

	program for adolescents because the population is very small and this is not an auto-assignment measure. Also, the childhood immunization rates are expected to rise with the implementation of the new CA legislation 277 that states children must have updated vaccines. Question Irene Conway from Governing Board (GB)/Member Advisory Committee (MAC): Can the HW LOB be considered to be included in the Hypertension program? Response: Yes, this can be considered. Comments: It is challenging for HW to be included because this LOB is overseen by San Francisco Health Network (SFHN) and not SFHP. Question Dr. Ellen Chen from SFHN: Can the Hypertension Incentive Program run throughout the year because this can lead to better access for patients? Response: SFHP can review this. <u>Health Plan (HP) CAHPS Results 2016:</u> Jess Strange, Program Manager of Care Experience reported the Adult HP CAPHS Results for 2016. This was the 2nd year that SFHP administered the HP-CAHPS survey. The	F/U Cassie Caravello: Can the HW LOB be considered to be included in the Hypertension program by 3/31/17? F/U Cassie Caravello: Can the Hypertension Program run throughout the year because this can lead to better access for patients by 3/31/17?	F/U Cassie Caravello: Can the HW LOB be considered to be included in the Hypertension program by 3/31/17? F/U Cassie Caravello: Can the Hypertension Program run throughout the year because this can lead to better access for patients by 3/31/17?

	surveys were only submitted in English, Spanish and Chinese. NCQA does not accept the submission of Chinese survey results and therefore SFHP will not be able to field Chinese surveys for formal NCQA accreditation. SFHP unsuccessfully tried to advocate with NCQA to change this. Thirteen points (out of a total 100 accreditation points) from CAHPS scores will be included with the NCQA 1st Survey this year the survey solicited qualitative data from members.
	
	• Response rate was 28% with Medicaid average 23%
	• SFHP scored below the NCQA 25th percentile in 7 composites.
	• Improvements were found in 6 composites compraed to last year:
	  o Rating of Health Plan
	  o Rating of Specialist Seen Most Often
	  o Rating of All Health Care
	  o Getting Needed Care
	  o Coordination of Care
	  o Customer Service
	• Decline in one composite in comparison to last year:
	  o Getting Care Quickly
	• Qualitative Data found members stated:
	  o "Not able to get appointment when I needed it."
	  o "I had to wait too long in the waiting room."
	• Organizational Strategic Goal for Getting		

	Care Quickly was 65.3% and Getting Needed Care was 66% • Survey vendor identified top priorities and indicated the key areas of improvement: o Ease of getting needed care, tests or treatment o SFHP Customer service provided needed information o Plan's written materials/Internet provided needed information o Made appointment for routine care at a doctor's office or clinic o Rating of Personal Doctor o Rating of Specialist seen most often • SFHP's next steps for improving access to care: o Access to Care Committee ongoing activities o Strategic Reserves Grants o Teladoc implementation Question from Ed Evans: MAC has not been happy with SFHP's Customer Service, which reflects the 80% satisfaction rate. Also, I feel that Customer Service is not aware of Medicare benefits. Response: Most plans showed their Customer Service rate at 87% and SFHP is trying to improve that by implementing a DHCS Performance Improvement Project that focuses on improving SFHP'scustomer service. Members are encouraged to files grievances		

	when services received do not meet their needs, including their experience with Customer Service. Question: Can the committee be updated about the results of the DHCS PIP project? Response: Yes, SFHP can bring the results to the committee. Question from Dr. Chen: Can you provide the data by provider or medical group level? Response: Next year we will be able to stratify the data at this level. Oversampling at the Medical Group level was not conducted in 2016. Question from Dr. Todd May from SFHN: Do you have any best practices to improve urgent care in hospitals? Response: Yes, I (Jess Strange) can send you a link <u>Opiate Update</u> Dr. Fiona Donald updated the committee about SFHP's Pain Management Program and associated opiate utilization trends. SFHP has seen excellent results because of multi-disiplinary providers within SFHP's network	F/U: Jess Strange will provide the results from the DHCS PIP Project, the required performance improvement project. F/U: Jess Strange to send Dr. May the link with urgent care best practices.	F/U: Jess Strange will provide the results from the DHCS PIP Project, the required performance improvement project. F/U: Jess Strange to send Dr. May the link with urgent care best practices.

	and across the city who serve the safety net population. Dr. Donald is the co-chair with Dr. Joseph Pace of SF Safety Net Pain Management Workgroup. The group meets six times a year. SFHP also offers has successful city-wide annual Pain Day training. The next Pain Day training will be in March or April 2017. • SFHP developed provider training materials and materials that are available on SFHP's website • Since April 2016, there are Continuing Medical Education modules available that targets use of opiates for acute pain etc. • Internal SFHP activities: o Pharmacy Critera revision for medications treating chronic pain o Utilization Management Policy to support best practices o PIP Pain Management measures SFHP has seen a decrease in total opiate utilization rates by SFHP members since 2013. PIP measure participation in pain management measure continues to increase. • Methadone was removed from SFHP's formulary and SFHP encourages providers to monitor current methadone-utilzing patients more closely. • External Activities: o Partnership with Bay Area Addiction Research and Treatment (BAART) o Care Management integration for opiate dependent high utilizers.		

	o Active engagement of at risk members into Care Management/Health Homes. Question from Dr. Kenneth Tai from NEMS: In the stats showing the down trend of total opiate use, is the Medi-Cal expansion included with these numbers? Response: Yes, this population is included. Also, Seniors and Persons with Disabilities (SPDs) included all populations demonstrate the downward trend. Question from Dr. Chen: Are there alternatives available for patients other than medication? Response: Medi-Cal now covers acupuncture for patients with severe, persistent pain. However SFHP's Provider Network Operations needs to establish a network for this. Also, Tom Waddell clinic has an integrated pain management program which offers alternative treatment modalities such as massage, group classes and acupuncture. Patient satisfaction at Tom Waddell is high. Comments: SFGH has a healing project and meditation classes are available. <u>Q4 2015/Q1 2016 Emergency Use of</u>		

	<u>Pharmaceuticals Report</u> In 2014, an audit finding from DHCS stated that SFHP did not evaluate 24/7 access to emergency medication and whether members were able to quickly access emergency medications. Dr. Glauber explained that this report was presented to DHCS in March 2016 which was preliminarily accepted. This report includes a deeper analysis of member ED visits for diagnosis for which there is a high probability of receiving an emergency medication, such as asthma, pneumonia, and urinary tract infection. The analysis demonstrated that in the vast majority of cases such members either received a timely medication from a network pharmacy or, after review of ED record, received medication treatment during the visit. This report will be presented to QIC quarterly. Question from Dr. Tai: Is there a way to review claims data for the time the member's picked up the medications? Response: Unfortunately, this data is not available to SFHP. Question from Dr. Chen: Sometimes pharmacies such as Walgreens do not have the medications that I prescribe in stock. Response: SFHP does not have direct access to	F/U Rebecca Au: Sometimes pharmacies such as Walgreens do not have the medications that I prescribe in stock.	F/U Rebecca Au: Sometimes pharmacies such as Walgreens do not have the medications that I prescribe in stock.

	this information.However, if you find that there is a specific medication not in stock at Walgreens, please relay to SFHP and we can invesitgate with Walgreens. Q4 2015 ED Report approved unanimously.		Approved: Q4 2015 ED Report approved unanimously.

QI Committee Chair's Signature & Date: _____9/23/16

Minutes are considered final only with approval by the QIC at its next meeting.

Agenda Item 1:

Action Item

Approval of Consent Calendar:

d. Credentialing and Recredentialing Recommendations

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MEMO

Date: October 25, 2016

To	Governing Board
From	James Glauber, MD Chair, Physician Advisory/Peer Review/Credentialing Committee
CC	
Regarding	Summary of SFHP Credentialing Activities (Aug - Sep 2016)

Recommendation:
San Francisco Health Plan (SFHP) completed the credentialing verification of the practitioner in the following table. No issues were found during the credentialing process.

SFHP Physician Advisory/Peer Review/Credentialing Committee recommends approval of the following practitioner to participate in the SFHP provider network.

PRACTITIONERS

NAME	DEGREE	BOARD	INITIAL / RECRED	LICENSE
Marquis, Joseph	MD	n/a	INITIAL	A127074

Agenda Item 2:
Action Item

- Review and Approval of the Annual Independent Audit Report for FY 2015-16

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Report of Independent Auditors

San Francisco Health Authority and San Francisco Community Health Authority

Chris Pritchard
Health Care Services Partner

Rianne Suico
Health Care Services Senior Manager

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Certified Public Accountants | Business Consultants

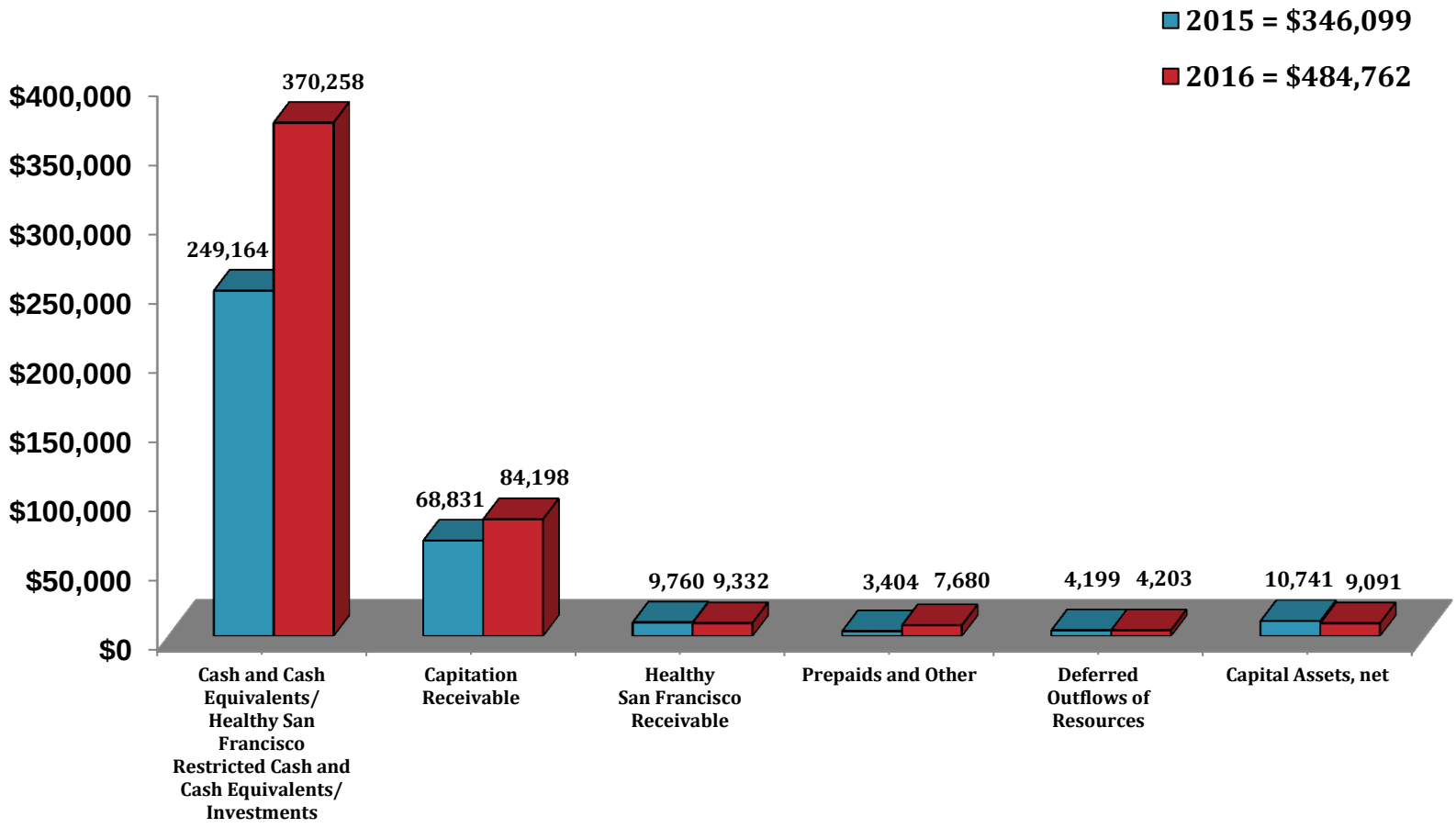
REPORT OF INDEPENDENT AUDITORS

Unmodified Opinion

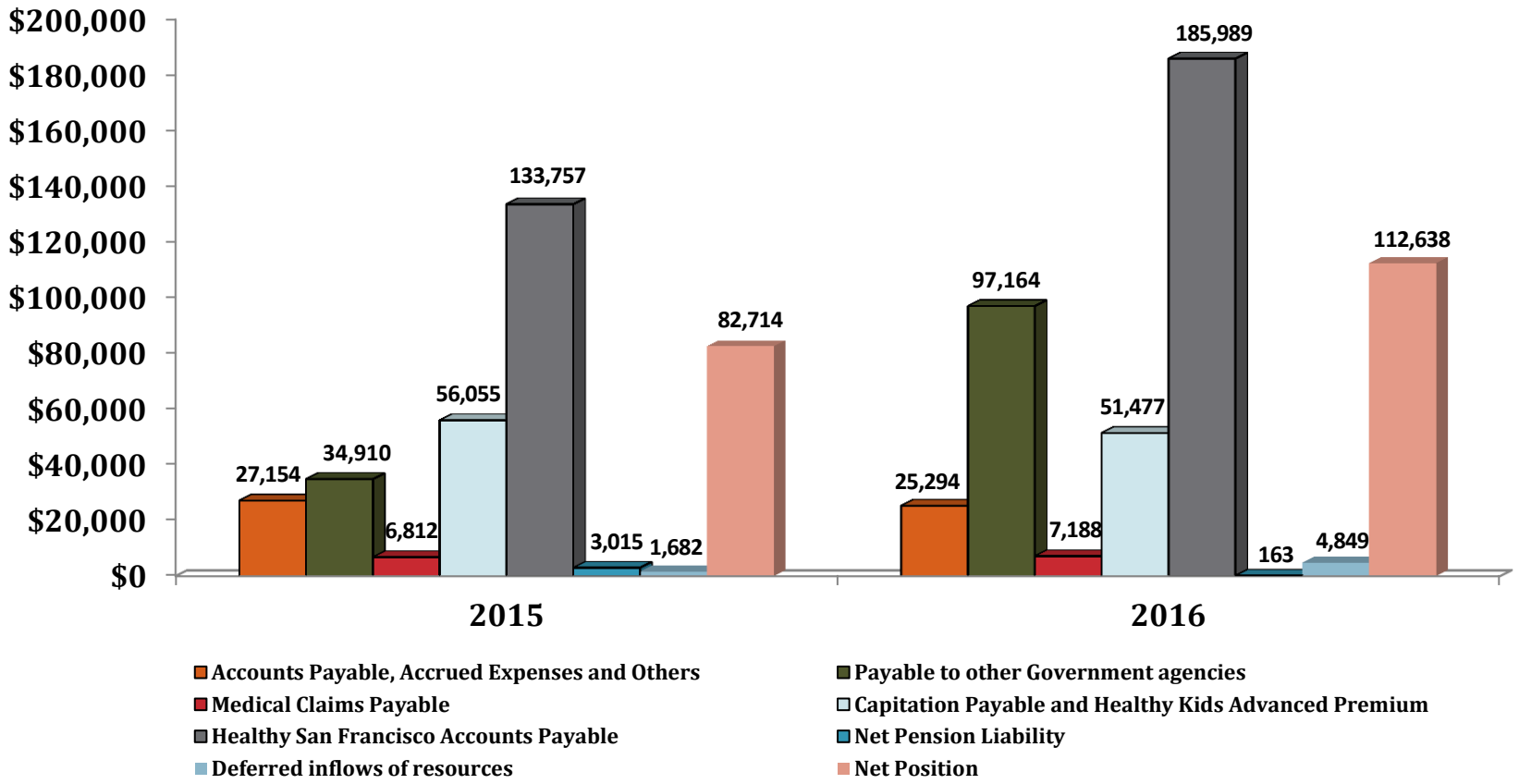
Combined financial statements are fairly presented in accordance with generally accepted accounting principles.

COMBINED STATEMENTS OF NET POSITION

ASSETS AND DEFERRED OUTFLOWS OF RESOURCES COMPOSITION
(IN THOUSANDS)

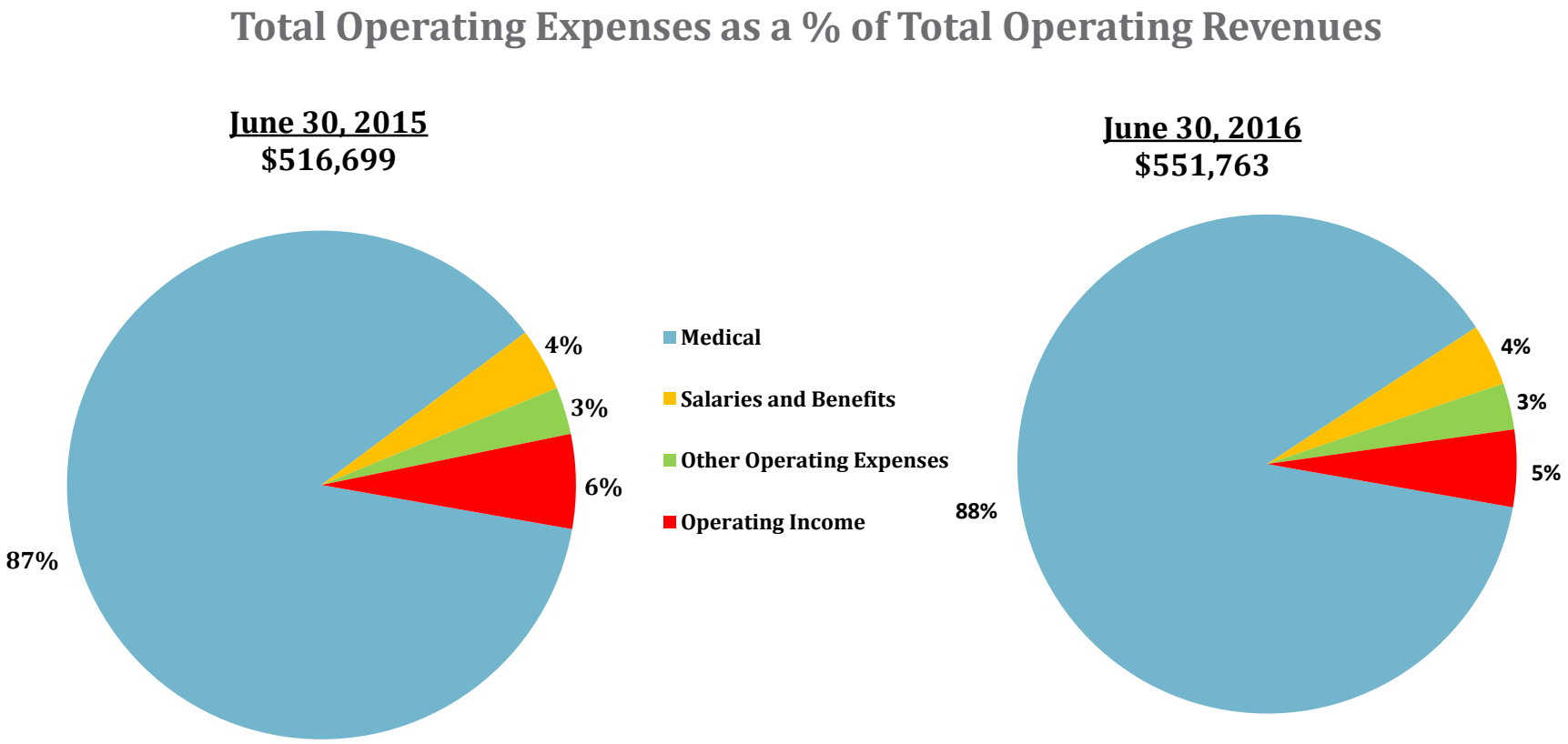


LIABILITIES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION BALANCE
(IN THOUSANDS)

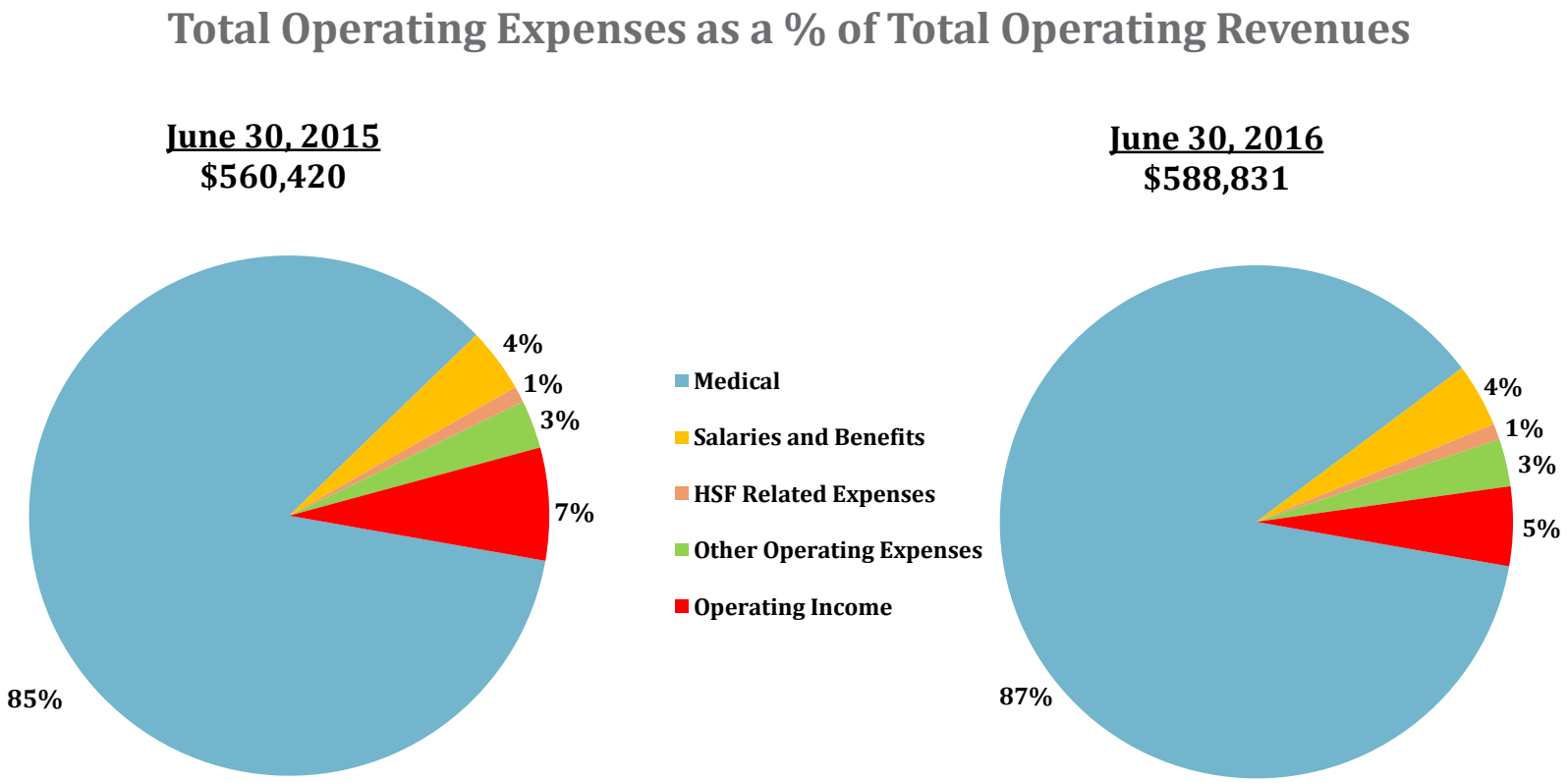


COMBINED OPERATIONS

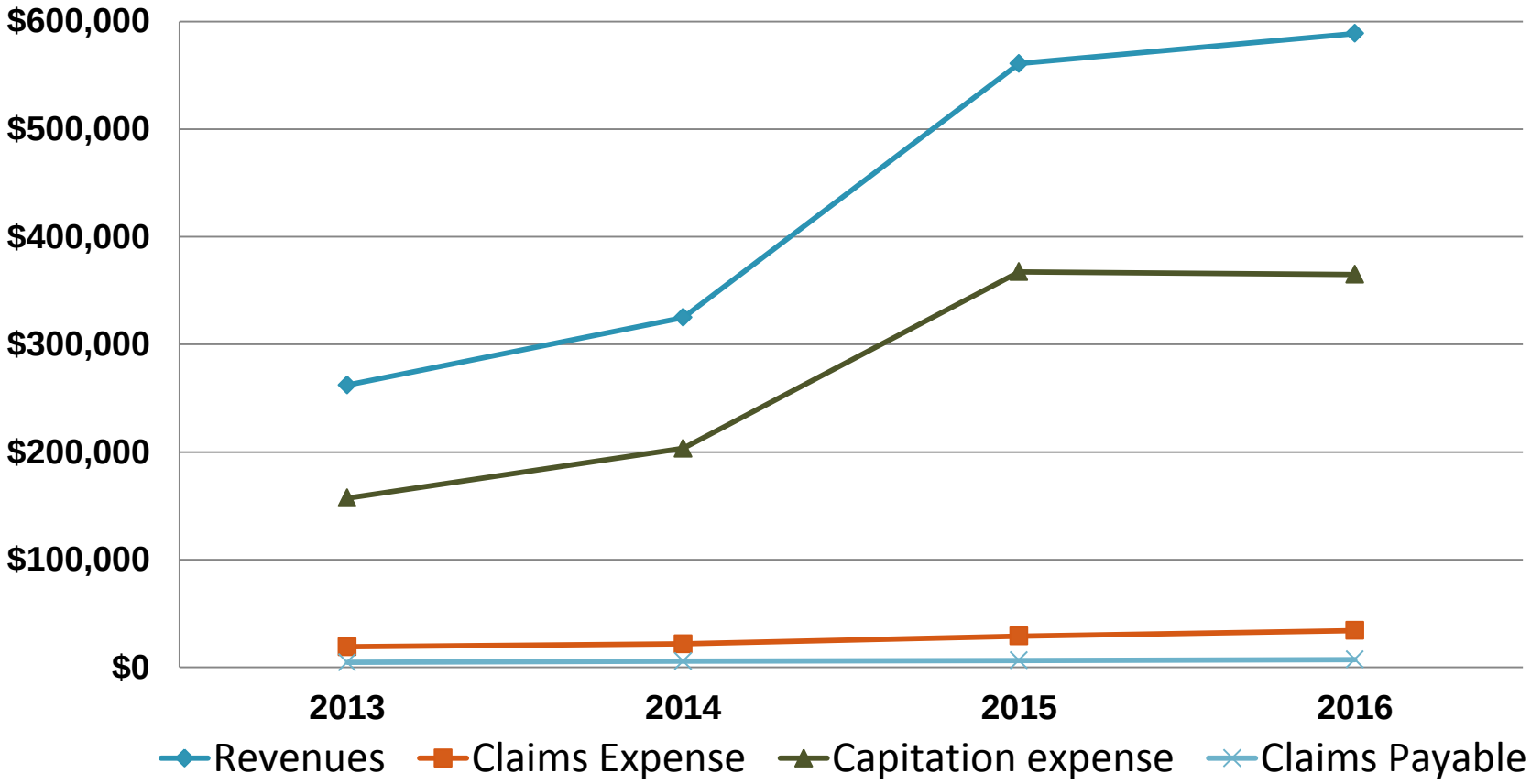
OPERATING EXPENSES (without HSF)
(IN THOUSANDS)



OPERATING EXPENSES
(IN THOUSANDS)

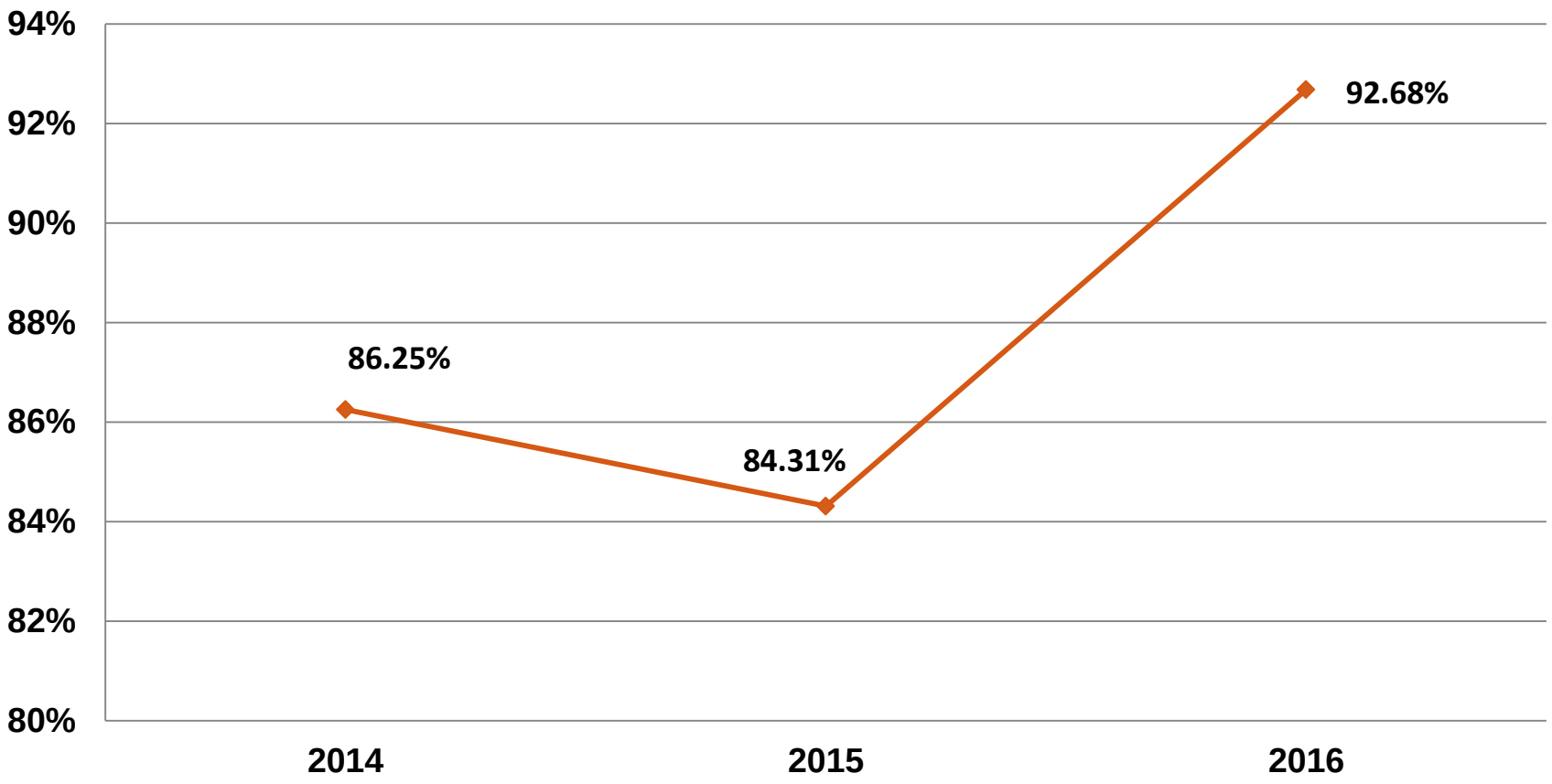


REVENUES, CLAIMS EXPENSE, AND CLAIMS PAYABLE
(IN THOUSANDS)



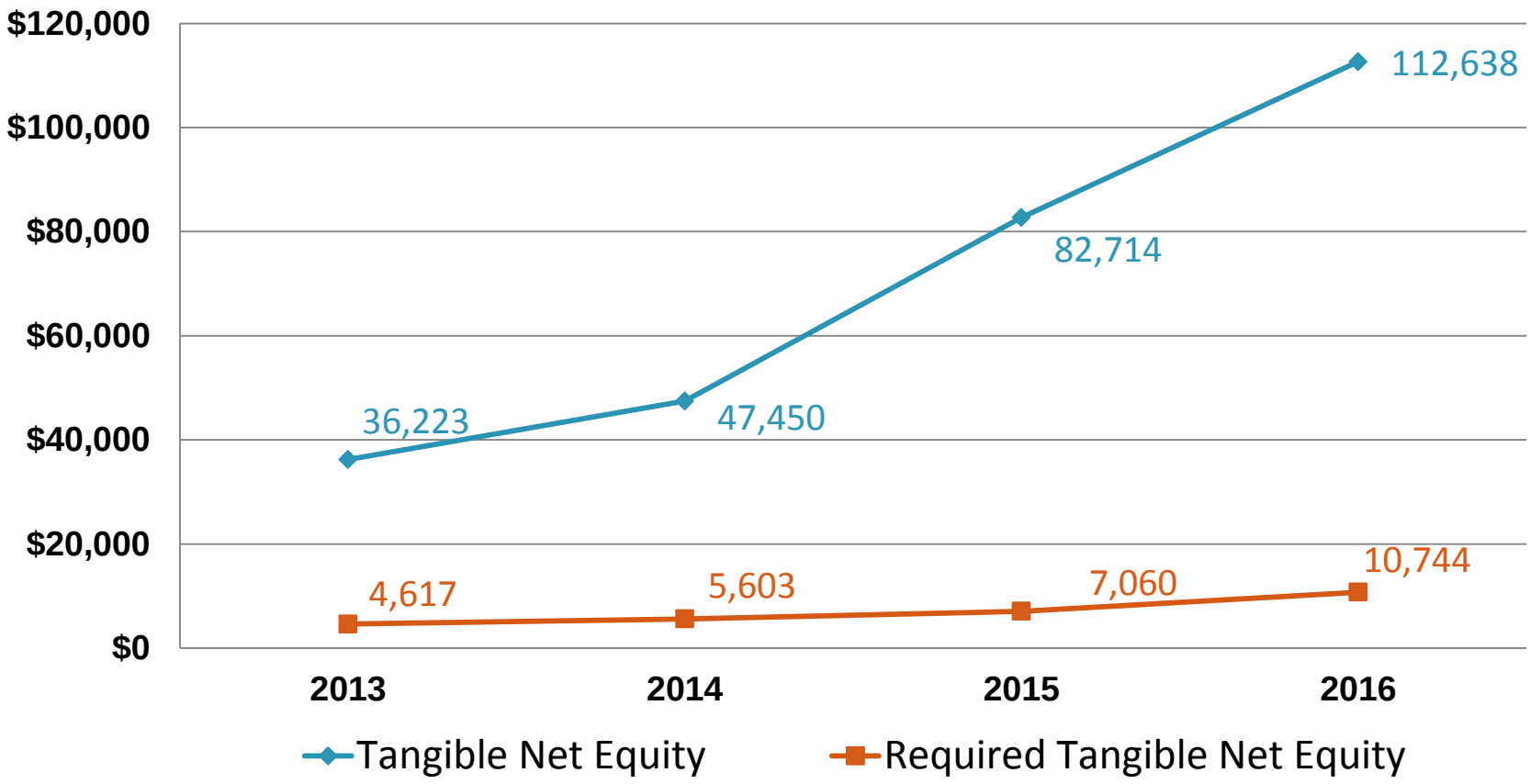
Source: Annual Department of Managed Health Care Filing and Audited FS

TREND OF MEDICAL LOSS RATIO FOR ALL LINES OF BUSINESS



Source: Medical loss ratio calculated using internal reports.

TANGIBLE NET EQUITY
(IN THOUSANDS)



Source: Annual Department of Managed Health Care Filing

IMPORTANT BOARD COMMUNICATIONS

- Significant accounting policies – AU-C 260
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- Internal controls best practice recommendation – AU-C 265

QUESTIONS?

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Communications with
Those Charged with Governance

San Francisco Health Authority and San Francisco Community Health Authority

June 30, 2016

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COMMUNICATIONS WITH THOSE CHARGED WITH GOVERNANCE

To the Governing Board
San Francisco Health Authority and San Francisco Community Health Authority

We have audited the combined financial statements of San Francisco Health Authority and the San Francisco Community Health Authority (collectively the "Plan") as of and for the year ended June 30, 2016, and have issued our report thereon dated October 21, 2016. Professional standards require that we advise you of the following matters relating to our audit.

OUR RESPONSIBILITY UNDER AUDITING STANDARDS GENERALLY ACCEPTED IN THE UNITED STATES OF AMERICA

As stated in our engagement letter dated February 18, 2016, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the combined financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and to design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we considered Plan's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the combined financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you

PLANNED SCOPE AND TIMING OF THE AUDIT

We discussed with management, who has been appointed by the Governing Board to oversee the audit, the planned scope and timing of our audit on June 13, 2016, and conducted our audit accordingly.

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SIGNIFICANT AUDIT FINDINGS AND ISSUES

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Plan are described in Note 2 to the combined financial statements. During the year, the Plan adopted Governmental Accounting Standards Board ("GASB") Statement No. 72, *Fair Value Measurement and Application*, GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments,* and GASB Statement No. 79, *Certain External Investment Pools and Pool Participants*. There have been no other new accounting policies adopted and there were no changes in the application of existing policies during fiscal year 2016. We noted no transactions entered into by the Plan during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the combined financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the combined financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the Plan's combined financial statements were:

- Management recorded an estimated liability for incurred but unrecorded claims expense. The estimated liability for unreported claims is based on management's estimate of historical claims experience and known activity subsequent to year end. We have an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon an historical experience methodology. We have an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management recorded an estimated payable to governmental agencies. The estimated payable for eligible Medi-Cal program beneficiaries is based upon estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- The useful lives of fixed assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

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- Management's estimate of the net pension liability is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

Actual results could differ from these estimates. In accordance with accounting principles generally accepted in the United States of America, any changes in these estimates are reflected in the Plan's combined financial statements in the year of change.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements relate to medical claims payable, fair value of investments, and capitation revenues.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no uncorrected misstatements whose effects, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction that could be significant to the Plan's combined financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 21, 2016.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Plan's combined financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

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Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the Plan that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the Plan within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Plan's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Governors and management of San Francisco Health Authority and San Francisco Community Health Authority and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
October 21, 2016

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October 21, 2016

Moss Adams LLP
101 Second Street, Suite 900
San Francisco, CA 94105

We are providing this letter in connection with your audits of the combined financial statements of San Francisco Health Authority and San Francisco Community Health Authority (collectively "the Plan"), which comprise the related combined statements of net position, statements of revenues, expenses, and changes in net position, and cash flows as of June 30, 2016 and 2015 and for the years then ended and the related notes to the combined financial statements for the purpose of expressing an opinion as to whether the combined financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $875,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the combined financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter,

Combined Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated February 18, 2016, for the preparation and fair presentation of the combined financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
6. All events subsequent to the date of the combined financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.
8. The following, if any, have been properly recorded or disclosed in the combined financial statements:
    a. Related-party transactions, including sales, purchases, loans, transfers, leasing arrangements, and guarantees, and amounts receivable from or payable to related parties.
    b. Guarantees, whether written or oral, under which the Plan is contingently liable.
    c. Significant estimates and material concentrations known to management that are required to be disclosed in accordance with the Government Accounting Standards Board ("GASB") Codification Section C50, *Claims and Judgments* [Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues,

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available sources of supply, or markets or geographic areas for which events could occur that would significantly disrupt normal finances within the next year.]

9. There are no estimates that may be subject to a material change in the near term that have not been properly disclosed in the combined financial statements. We understand that *near term* means the period within one year of the date of the combined financial statements. In addition, we have no knowledge of concentrations existing at the date of the combined financial statements that make The Plan vulnerable to the risk of severe impact that have not been properly disclosed in the combined financial statements. We understand that concentrations include individual or group concentrations of payors, members, suppliers, lenders, products, services, sources of labor or materials, licenses or other rights, or operating areas or markets. We further understand that *severe impact* means a significant financially disruptive effect on the normal functioning of the Plan.

Information Provided

10. We have provided you with:
    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the combined financial statements such as records, documentation and other matters;
    b. Minutes of the meetings of the Board of Governors, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;
    c. Additional information that you have requested from us for the purpose of the audit;
    d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
11. We acknowledge our responsibility for the design and implementation of programs and controls to prevent and detect fraud. We understand the term "fraud" includes misstatements arising from fraudulent financial reporting and misstatements arising from misappropriation of assets. Misstatements arising from fraudulent financial reporting are intentional misstatements, or omissions of amounts or disclosures in the combined financial statements to deceive financial statement users. Misstatements arising from misappropriation of assets involve the theft of an entity's assets where the effect of the theft causes the condensed interim combined financial information not to be presented in conformity with accounting principles generally accepted in the United States of America.
12. All transactions have been properly recorded in the accounting records and are reflected in the combined financial statements.
13. Receivables recorded in the combined financial statements represent valid claims for charges arising on or before June 30, 2016 and 2015.
14. We have disclosed to you the results of our assessment of the risk that the combined financial statements may be materially misstated as a result of fraud.
15. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—
    a. Board of Governors,
    b. Management,
    c. Employees who have significant roles in internal control, or
    d. Others when the fraud could have a material effect on the combined financial statements.
16. We have no knowledge of any allegations of fraud or suspected fraud, affecting the Plan's combined financial statements communicated by employees, former employees, analysts, regulators or others.
17. There are no—
    a. There are no violations or possible violations of laws or regulations that exist, such as those related to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the combined financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the combined financial statements. This is including, but not limited to, the antikickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.

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b. Possible illegal acts brought to the attention of management.

c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.

18. The Plan has no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.

19. The Plan has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral.

20. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the combined financial statements.

21. We have disclosed to you the identity of the Plan's related parties and all the related party relationships and transactions of which we are aware.

22. The Plan has complied with all aspects of contractual agreements that would have a material effect on the combined financial statements in the event of noncompliance.

23. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the combined financial statements or on the disclosure in the notes to the combined financial statements.

24. We have disclosed to you any change in the Plan's internal control over financial reporting that occurred during the Plan's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Plan's internal control over financial reporting.

25. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction, including those related to Medicare and Medicaid antifraud and abuse statutes; deficiencies in financial reporting practices; or other matters that could have a material adverse effect on the combined financial statements.

26. The liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims, has been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of June 30, 2016 and 2015. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.

27. We have determined the liability for health unpaid claims and claims adjustments expenses related to Community-Based Adult Services ("CBAS") members are immaterial to the combined financial statements as of June 30, 2016 and 2015. As such, no liability is recorded in the combined financial statements at year-end.

28. We agree with the findings of specialists in evaluating the liability for health unpaid claims and claims adjustment expenses and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the combined financial statements and underlying accounting records. We do not give or cause any instructions to be given to specialists with respect to values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have an impact on the independence or objectivity of the specialist.

29. The liability for the difference between the required 85% medical loss ratio included in the liability for health unpaid claims and claims adjustment expenses for eligible individuals under the Affordable Care Act ("ACA") has been determined using appropriate claims and encounters data and calculated in accordance with our Medi-Cal contract. The estimated liability is to the best of our knowledge and belief as of June 30, 2016 and 2015.

30. We believe that the actuarial assumptions and methods used to measure pension liabilities and costs for financial accounting purposes are appropriate in the circumstances. We agree with the findings of CalPERS (specialist) in evaluating our pension liabilities and costs and have adequately considered the qualifications of CalPERS (specialist) in determining the amounts and disclosures used in the combined financial statements and underlying accounting records. We did not give or cause any instructions to be given to CalPERS (specialist) with

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respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of CalPERS (specialists).

31. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

32. All reinsurance transactions entered into by the Plan are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Plan's reinsurance arrangements meet the risk transfer provisions of GASB Codification Section P20, *"Public Entity Risk Pools"*, or are accounted for as deposits.

33. The Plan has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan Act of 1975.

34. The Plan has appropriately reconciled its books and records (e.g., general ledger accounts) underlying the combined financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the combined financial statements. There were no material unreconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.

35. In regards to your assistance with drafting the combined financial statements, we have:

    a. Made all management decisions and performed all management functions.

    b. Designated an individual with suitable skill, knowledge, or experience to oversee the services.

    c. Evaluated the adequacy and results of the services performed.

    d. Accepted responsibility for the results of the services.

    e. Established and maintained internal controls, including monitoring of ongoing activities

36. We acknowledge that U.S. GAAP presents premium tax fees in the combined financial statements as an administrative, operating expense. However, management has elected to present the premium tax fee as a contra revenue item in the combined statements of revenues, expenses and change in net position. This approach is an alternative presentation that we confirmed to be acceptable by the Department of Health Care Services who regulates the current industry financial reporting.

37. Risk sharing, quality improvement, provider incentive, and other arrangements with providers wherein the Plan is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the combined financial statements at net realizable value, giving consideration to all amounts due under arrangements. We believe these liabilities are fairly stated as of June 30, 2016 and 2015.

38. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Plan; a significant customer may be unable to purchase from the Plan; or a significant service provider may be unable to provide services to the Heath Plan, in each case because of their respective inability to comply with HIPAA.

39. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Plan's audit.

40. To our knowledge, there are no instances where any officer or employee of the Plan has an interest in a company with which the Plan does business that would be considered a "conflict of interest." Such an interest would be contrary to the Plan's policy.

41. We acknowledge our responsibility for presenting the Management's Discussion and Analysis required by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115, in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion and Analysis is measured and presented in accordance with the prescribed guidelines. The methods of measurement and

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presentation of the Management's Discussion and Analysis have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

42. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the combined financial statements of the Plan are properly disclosed.

43. We believe that the actuarial assumptions and methods used to measure net pension liability for financial accounting purposes are appropriate in the circumstances.

44. We have adopted the provisions of GASB 72, Fair Value Measurement and Application, and reflected the adoption in the combined financials as of June 30, 2016 and 2015.

45. We have not completed the process of evaluating the impact that will result from adopting GASB 80, Blending Requirements for Certain Component Units, as discussed in Note 2. The Plan is therefore unable to disclose the impact of adopting GASB 80 will have on its combined financial position and the combined results of operations when such statements are adopted.

46. With regard to the fair value measurements and disclosures of investments in equity and debt securities, we believe that:

    a. The measurement methods, including the related assumptions, used in determining fair value were appropriate and were consistently applied.

    b. The completeness and adequacy of the disclosures related to the fair values are in conformity with Governmental Accounting Standards Board Statement No. 61, The Financial Reporting Entity: Omnibus and amendment of GASB Statements No. 14 and No. 24, Governmental Accounting Standards Board Statement No. 72, Fair Value Measurement and Application, and Governmental Accounting Standards Board Statement No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.

    c. No events have occurred subsequent to June 30, 2016 that requires adjustment to the fair value measurements and disclosures included in the combined financial statements.

47. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe no premium deficiency reserves are necessary at June 30, 2016 and 2015, respectively.

48. Healthy San Francisco accounts payable is properly classified as current assets on the combined statements of net position as these amounts are due on demand to participating employers and employees of the Healthy San Francisco program.

49. We confirm we are subject to the audit requirements of the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and in compliance with the State Controller's Office prescribed reporting guidelines.

To the best of our knowledge and belief, no events have occurred subsequent to the combined statements of net position date and through the date of this letter that would require adjustment to or disclosure in the aforementioned combined financial statements.

John Grgurina, CEO

John Gregoire, CEO

Skip Bishop, Director of Accounting

Communication of
Internal Control Related Matters

San Francisco Health Authority and San Francisco Community Health Authority

June 30, 2016

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COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS

To the Management and Governing Board
San Francisco Health Authority and San Francisco Community Health Authority

In planning and performing our audit of the financial statements of San Francisco Health Authority (the Company), as of and for the year ended June 30, 2016, in accordance with auditing standards generally accepted in the United States of America, we considered the Company's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

We did note the following item that management might consider as best practice recommendations. We believe the following operational or administrative recommendation may be of a potential benefit to the Plan:

Executive expense report reimbursement

Observation: During our review of the approval process for executive team member credit card expenses, we noted the Company does not have a credit card policy in place or a formal procedure for the submission or review of expense reports. The expenses for executives are typically approved by the Chief Executive Officer (CEO). However, there is no review of the CEO's expense reports.

Recommendation: We recommend the Company develop and implement a formal credit card and employee expense reimbursement policy and procedures. Additionally, we recommend having a member of the governing board review the CEO's expense reimbursement requests prior to processing for payment.

Management's Response: We will enhance the current disbursement and credit card policies to formalize the process with respect to submission and approval with considerations for review of executive expenses by a governing board or finance committee member.

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Great Plains User Access

Observation: During our cash management walkthrough, we observed that certain members of the finance team have the access to enter new vendors in the system and process accounts payable checks.

Recommendation: We recommend the Company review their existing user access policy to preserve appropriate segregation of duties.

Management's Response: We have developed a tool for reporting user access and security roles for the financial system and periodically review this report to ensure staff roles are appropriate. We will review the existing user access policy to ensure segregation of duties is maintained at the individual user security role in the financial system.

Reports over cybersecurity attacks

Observation: During the conduct of our audit we noted there is not a formal policy for monitoring and reporting of attempted breaches and attacks on the Company's network. One of the key performance indicators for how well an organization's current cybersecurity strategy is working is the number of thwarted breach attempts and attacks on the organization's network. Regular reporting on the number of attacks and the number of nullified attacks helps management determine the effectiveness of the defense measures implemented, as well as determine if additional measures are needed given the volume of continuing and varied attacks.

Recommendation: We recommend that IT management provide visibility to the Company's officers on the number of attacks it sustains over various timeframes (e.g., daily, weekly) and the success at defeating them. This reporting could be in the form of verbal reports during regularly scheduled management meetings or via a dashboard on the company's intranet site that is available to all employees to view if interested.

Management's Response: SFHP has several related policies and procedures for monitoring and reporting attempted breaches and attacks on the Plan's network. In particular, SFHP has the following policies and procedures: IS-08, Access Controls, IS-15, System Security Review and Host-Based Intrusion Detection and C&RA-06, PHI Breach Investigation.

IS-08, Access Controls: This policy and procedures helps to prevent attacks by allowing access to SFHP systems to only those persons or software programs that have been granted access on a role-based access controls for al user authentications. SFHP IT department maintains log files to expose when and how accounts are being modified. Remote access is also limited and monitored by SFHP. All VPN users are required to use Two Factor Authentication.

IS-15, System Security Review and Host-Based Intrusion Detection: This policy and procedure outlines the processes to detect attacks including the system security reviews that are conducted to identify, define and prioritize risks to SFHP, including administrative and technical vulnerability scanning tools. System security reviews are conducted formally, and are documented in the risk analysis process. SFHP information systems that are accessible via the internet use a comprehensive third-party host-based intrusion detection and prevention system. This would include attempted breaches and attacks on the SFHP network.

C&RA 06, PHI Breach Investigation and Reporting: This policy and procedure outlines the steps taken by employees when there is a discovery of a breach, which would include a cyberattack. Any breaches are reported to the appropriate agencies, Policy and Compliance Committee, the Compliance Officer, the Security Officer and the SFHP Board (the Executive Team is also informed).

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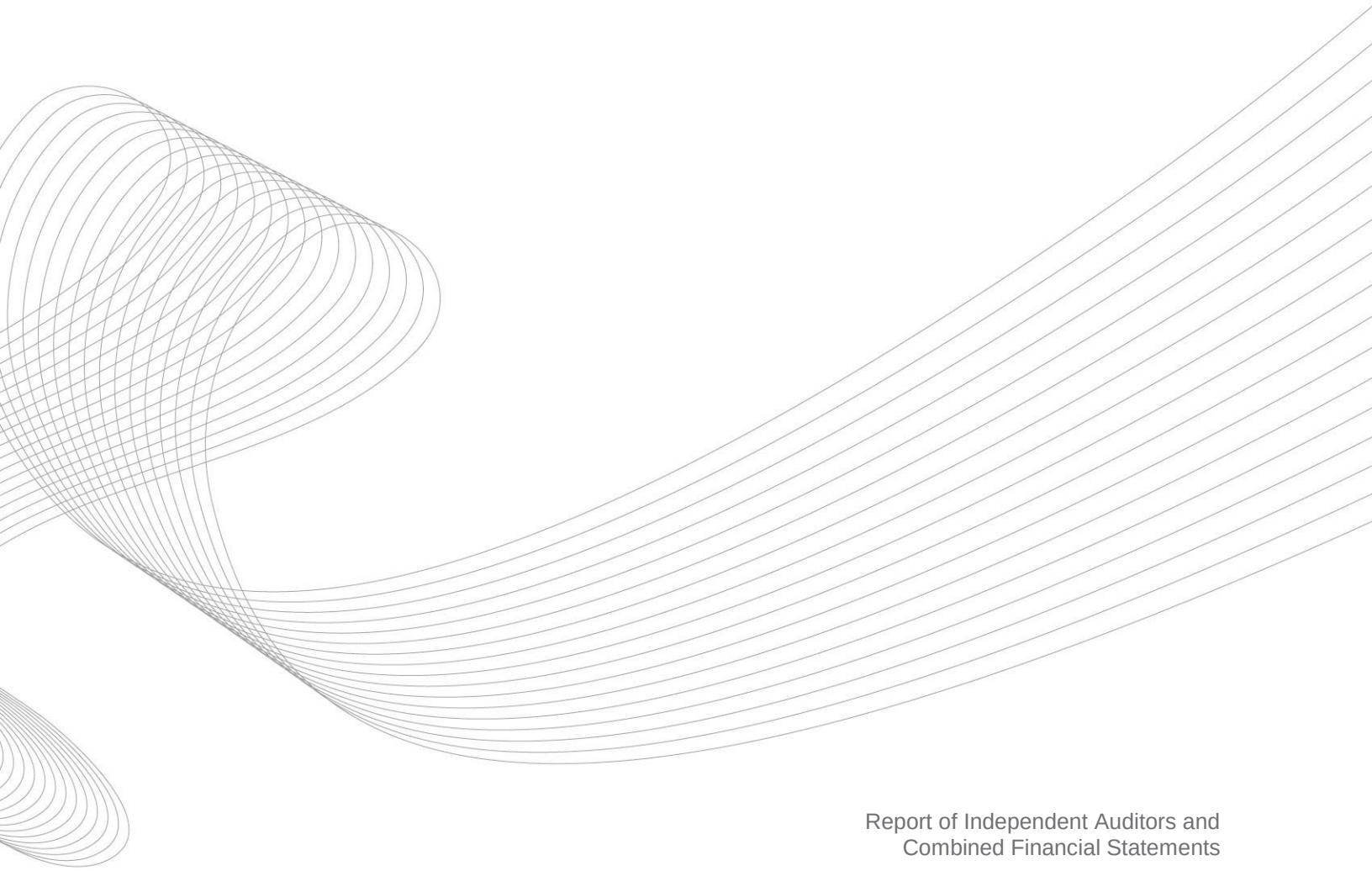
SFHP regularly runs detailed reports on the number of attacks it sustains over various timeframes (e.g., daily, weekly, monthly) and SFHP's success at defeating them. These reports show viruses, trojans and other kinds of malware that include IP addresses, machine names, timestamps and attack categories. In addition anomalies that include suspicious file accesses, unusual file changes and large volumes of file copying trigger real time alerts that are monitored and investigated by IT personnel, including the Security Officer. In addition, SFHP also uses a syslog collection and log correlation system for analysis and early detection of security incidents and threat management. Real time alerts are created for various systems and security events, including system level changes, access permission changes, user monitoring and potential threats.

A summary report will be provided to the Management Team on a monthly basis and will be included in the semi-annual report to the Board.

This communication is intended solely for the information and use of management, the Governing Board, and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
October 21, 2016



Report of Independent Auditors and
Combined Financial Statements

San Francisco Health Authority and San Francisco Community Health Authority

June 30, 2016 and 2015

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CONTENTS

MANAGEMENT'S DISCUSSION AND ANALYSIS

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The management's discussion and analysis of the San Francisco Health Authority and San Francisco Community Health Authority (collectively, the "Plan"), is intended to provide readers and interested parties with an overview of the Plan's financial activities for the fiscal years ended June 30, 2014, 2015, and 2016. It should be reviewed in conjunction with the Plan's combined financial statements and accompanying notes to enhance the reader's understanding of the Plan's financial performance.

Overview of the Plan's Combined Financial Statements

The Plan's annual financial report includes the combined results for the San Francisco Health Authority and San Francisco Community Health Authority. The latter entity was formed on July 1, 2005, to segregate for reporting purposes, Healthy Families, Healthy Workers, and Healthy Kids programs. The former retains the Medi-Cal program only. The combined reports contain the annual combined financial statements and related notes, which reflect the Plan's combined financial condition and changes in combined financial position for the fiscal years ended June 30, 2014, 2015, and 2016. The combined financial statements include the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows as well, as the notes to the combined financial statements. These statements report the following financial information:

- The combined statements of net position summarize the Plan's assets, liabilities, and net position as of June 30, 2014, and the Plan's assets and deferred outflows of resources, liabilities, deferred inflows of resources and net position as of June 30, 2015 and 2016.

- The combined statements of revenues, expenses, and changes in net position present the results of operations during the fiscal years ended June 30, 2014, 2015, and 2016.

- The key operating indicators report significant operating statistics and changes as of June 30, 2014, 2015, and 2016.

Financial Position Highlights

The financial position of the Plan, as reported in the combined statements of net position, remained strong as of June 30, 2014, 2015, and 2016. Significant changes included the following:

- Total assets and deferred outflows of resources increased by $138,663,507 to $484,762,255 as of June 30, 2016, from $346,098,748 as of June 30, 2015, primarily from increases in Plan cash deposits, Healthy San Francisco cash deposits and Plan receivables.

  Total assets and deferred outflows of resources increased by $128,655,909 to $346,098,748 as of June 30, 2015, from $217,442,839 as of June 30, 2014, primarily from increases in Plan cash deposits, Healthy San Francisco cash deposits, Plan receivables and deferred outflows of resources related to pensions.

- Capital assets, net of accumulated depreciation, decreased by $1,650,209 to $9,091,201 as of June 30, 2016, from $10,741,410 as of June 30, 2015, as a result of recording $1,933,542 in depreciation expense partially offset by net capital asset additions of $283,333.

  Capital assets, net of accumulated depreciation, increased by $4,163,424 to $10,741,410 as of June 30, 2015, from $6,577,986 as of June 30, 2014, as a result of new office relocation, opening an offsite service center and an offsite data center.

- Net position increased by $29,923,513 to $112,637,842 as of June 30, 2016, from $82,714,329 as of June 30, 2015, due to having full Medi-Cal Expansion membership for the entire fiscal year, increased membership in other Medi-Cal categories of aid, a lower than expected Medical Loss Ratio (MLR) for the Medi-Cal Non-SPD line of business and margin and rebates related to Hepatitis C treatment activity.

  Net position increased by $35,264,499 to $82,714,329 as of June 30, 2015, from $47,449,830 as of June 30, 2014, due to having full Medi-Cal Expansion membership for the majority of the fiscal year. Net position also increased due to excess Patient Protection and Affordable Care Act 1202 ("ACA 1202") receipts over enhanced payments to primary care physicians as well as the Medi-Cal realignment of the Family and Targeted Low Income Children to Adults 19 and Over and Children 18 and Under categories of aid.

- The current ratio (current assets divided by current liabilities) of 1.23 as of June 30, 2016, increased from 1.21 as of June 30, 2015. This increase is driven by increases in cash deposits and capitation receivables.

  The current ratio (current assets divided by current liabilities) of 1.21 as of June 30, 2015, increased from 1.12 as of June 30, 2014. This increase is driven by increases in cash deposits and capitation receivables.

  The current ratio (current assets divided by current liabilities) of 1.12 as of June 30, 2014, increased from 1.07 as of June 30, 2013. This slight increase is driven by increases in cash deposits and capitation receivables.

Key Operating Indicators

Changes in member months, revenue yield, and efficiency ratios are highlighted below:

	Fiscal Years Ended June 30			Net Change 2016 - 2015		Net Change 2015 - 2014	
Key Operating Indicators	**2016**	**2015**	**2014**	**$**	**%**	**$**	**%**
Member months							
Medi-Cal	1,568,967	1,392,574	929,828	176,393	12.67%	462,746	49.77%
Healthy Kids	24,021	25,761	26,617	(1,740)	-6.75%	(856)	-3.22%
Healthy Workers	139,171	144,560	142,604	(5,389)	-3.73%	1,956	1.37%
Total member months	1,732,159	1,562,895	1,099,049	169,264	10.83%	463,846	42.20%
Capitation revenue, net of premium tax	$ 572,752,947	$ 545,115,541	$ 311,858,180	$ 27,637,406	5.07%	$ 233,257,361	74.80%
Healthy San Francisco administration fee	6,092,632	5,364,768	6,673,113	727,864	13.57%	(1,308,345)	-19.61%
Interest income	805,530	497,416	751,420	308,114	61.94%	(254,004)	-33.80%
Other income and grants	9,985,109	9,939,400	5,616,408	45,709	0.46%	4,322,992	76.97%
	589,636,218	560,917,125	324,899,121	28,719,093	5.12%	236,018,004	72.64%
Operating expenses							
Medical expenses	510,858,596	477,781,679	280,514,003	33,076,917	6.92%	197,267,676	70.32%
Administrative expenses	48,854,109	45,351,029	33,158,145	3,503,080	7.72%	12,192,884	36.77%
Total operating expenses	559,712,705	523,132,708	313,672,148	36,579,997	6.99%	209,460,560	66.78%
Change in net position	$ 29,923,513	$ 37,784,417	$ 11,226,973	$ (7,860,904)	-20.80%	$ 26,557,444	236.55%
Per member per month ("pmpm")							
Capitation revenue	330.66	348.79	283.75	(18.13)	-5.20%	65.04	22.92%
Interest income	0.47	0.32	0.68	0.15	46.88%	(0.36)	-52.94%
Other income and grants	5.76	6.36	5.11	(0.60)	-9.43%	1.25	24.46%
Operating expense							
Medical expense	294.93	305.70	255.23	(10.77)	-3.52%	50.47	19.77%
Administrative expense	28.20	29.02	30.17	(0.82)	-2.83%	(1.15)	-3.81%
Change in net position	17.28	24.18	10.22	(6.90)	-28.54%	13.96	136.59%
Medical cost ratio	89.19%	87.65%	89.95%	1.54%	1.76%	-2.30%	-2.56%
Administrative cost ratio	5.72%	5.51%	6.69%	0.21%	3.81%	-1.18%	-17.64%

Enrollment and membership

The overall change in net member months from June 30, 2015 to June 30, 2016, was an increase of 10.83%. The total number of member months was 4.3% above our budget. In 2016, the Plan experienced a 12.67% increase in Medi-Cal membership, and a 3.73% decrease in Healthy Workers membership. Health care reform known as the Affordable Care Act ("ACA") contained a provision allowing states to expand their Medicaid program effective January 1, 2014. California elected to expand the Medi-Cal program and as a result the Plan enrolled 56,386 Medi-Cal Expansion ("MCE") members as of June 30, 2016. This new MCE membership generated 649,378 member months for fiscal year 2016 compared to a budget of 556,451 member months.

The overall change in net member months from June 30, 2014 to June 30, 2015, was an increase of 42.20%. The total number of member months was 10.98% above our budget. In 2015, the Plan experienced a 49.77% increase in Medi-Cal membership, and a 1.37% increase in Healthy Workers membership. Health care reform known as the Affordable Care Act ("ACA") contained a provision allowing states to expand their Medicaid program effective January 1, 2014. California elected to expand the Medi-Cal program and as a result the Plan enrolled 47,887 Medi-Cal Expansion ("MCE") members as of June 30, 2015. This new MCE membership generated 484,353 member months for fiscal year 2015 compared to a budget of 398,818 member months.

Healthy Kids –Net membership from June 30, 2015 to June 30, 2016, decreased by 6.75% largely due to the continued migration of low-income families out of San Francisco due to the economy and choice of schools.

Net membership from June 30, 2014 to June 30, 2015, decreased by 3.22% largely due to the continued migration of low-income families out of San Francisco due to the economy and choice of schools.

Healthy Workers – Net membership from June 30, 2015 to June 30, 2016, decreased 3.73%. This was lower than the projected target for fiscal year 2016. As was the case during fiscal year 2015, we projected the membership to remain flat due to changes in eligibility requirements for In-Home Supportive Services ("IHSS"). Eligibility criteria changes implemented by the State ultimately resulted in a decrease in membership. This decrease is likely due to a decrease in the base of potential eligible Healthy Workers members (fewer people becoming IHSS workers).

Net membership from June 30, 2014 to June 30, 2015, increased 1.37%. This was higher than the projected target for fiscal year 2015. As was the case during fiscal year 2014, we projected the membership to remain flat due to changes in eligibility requirements for In-Home Supportive Services ("IHSS"). Eligibility criteria changes implemented by the State ultimately resulted in an increase in membership. This increase is likely due to an increase in the base of potential eligible Healthy Workers members (more people becoming IHSS workers) or a greater enrollment response rate to the current base of potential eligible members.

Operating revenues

The increase in capitation revenues, net of premium tax reported for the fiscal year ended June 30, 2016, of $27.64 million (5.07%), was due to the significant increase in the number of Medi-Cal members participating in Hepatitis-C treatment programs. The Plan receives a "kick" or supplemental payment to help cover these high cost drugs. Hepatitis-C kick payments contributed $36.65 million in capitation revenue during the fiscal year. The Plan experienced a 29% reduction in the capitation revenue rate for the MCE population. Increasing MCE membership helped to offset the steep rate reduction. MCE capitation revenue decreased by $6.42 million for the fiscal year. Healthy Workers capitation revenue decreased by $1.83 million for the fiscal year

The increase in capitation revenues, net of premium tax reported for the fiscal year ended June 30, 2015, of $233.26 million (74.80%), was primarily due to Medi-Cal expansion. The new MCE population contributed $257.50 million in capitation revenues during the fiscal year. The remainder of the increase was due to membership growth in other Medi-Cal categories of aid as well as excess receipts over enhanced payments to primary care physicians related to ACA 1202 and kick premiums related to new Hepatitis-C treatment programs.

Healthy San Francisco ("HSF")

The Plan provides Third Party Administration ("TPA") for the City of San Francisco Department of Public Health's program for uninsured residents. Services provided include participant billing, enrollment, customer service call center, processing employer payments, and managing the Medical Reimbursement Accounts ("MRA"). With the introduction of MCE effective January 1, 2014, approximately 10,000 HSF participants transitioned to the Medi-Cal program. The number of participants has steadily declined since this transition. The total amount of the reimbursement was $6.09 million for 2016 compared to $5.37 million for 2015. The total amount of the reimbursement was $5.37 million for 2015 compared to $6.67 million for 2014.

Medical expense

Total medical expenses increased by $33.08 million or 6.92% over 2015 primarily from the following categories:

- In 2016, total hospital and professional expense decreased by $15.06 million, or 3.94%. The majority of this decrease is due to provider capitation rate reductions for the MCE membership.

- In connection with MCE effective January 1, 2014, the State mandated that all health plans maintain a minimum medical loss ratio ("MLR") of 85% for the period of January 1, 2014 through June 30, 2015. Failure to meet this minimum requirement may result in the return of a portion of the MCE premium revenue. In order to meet the MLR requirement, the Plan established a special reserve during fiscal year 2015. The balance in the special reserve was $7.38 million as of June 30, 2015. The State also mandated that all health plans maintain a minimum MLR of 85% for the period of July 1, 2015 through June 30, 2016. The Plan finished the year with a MLR of 92.7% which is well above the minimum threshold. As a result, no reserve was required.

- In 2016, total pharmacy expense increased by $34.27 million, or 62.68%. The majority of this increase is related to costs for Hepatitis-C treatment programs.

Total medical expenses increased by $197.27 million or 70.32% over 2014 primarily from the following categories:

- In 2015, total hospital and professional expense increased by $183.97 million, or 80.91%. The majority of this increase is due to capitation and fee-for-service expenses related to MCE membership. The Plan also expensed $12.0 million in distributions to its providers.

- In connection with MCE effective January 1, 2014, the State mandated that all health plans maintain a minimum medical loss ratio ("MLR") of 85% as of June 30, 2015. Failure to meet this minimum requirement may result in the return of a portion of the MCE premium revenue. In order to meet the MLR requirement, the Plan established a special reserve during fiscal year 2015. The balance in the reserve was $7.38 million as of June 30, 2015.

- In 2015, total pharmacy expense increased by $19.45 million, or 55.91%. The majority of this increase is related to MCE membership and costs for Hepatitis-C treatment programs.

Administrative expenses

Administrative expenses increased in 2016 by $3.50 million, or 7.72%, from 2015 driven by increases in salaries and benefits, increases in office lease costs related to the 50 Beale Street, the SFHP Service Center, and the Santa Clara IT data center properties and increases in third-party administrative fees from PerformRx (pharmacy benefits management) and Beacon Health Strategies (non-specialty mental health).

Administrative expenses increased in 2015 by $12.20 million, or 36.77%, from 2014 driven by increases in salaries and benefits, and professional/consulting costs related to the office relocation to Beale Street, the opening of the SFHP Service Center and the relocation of the IT data center to Santa Clara.

Results of operations

The Plan generated an operating income of $29.12 million in 2016 compared with an operating income of $37.29 million in 2015. Excluding HSF TPA business, the Plan incurred an operating income of $29.11 million in 2016. HSF alone generated an operating and total profit of $1,668. Grant income for the Healthy Kids program and administrative fees for claims processing and EDI services increased by $45,709, or 0.46%.

The Plan generated an operating income of $37.29 million in 2015 compared with an operating income of $10.48 million in 2014. Excluding HSF TPA business, the Plan incurred an operating income of $37.28 million in 2015. HSF alone generated an operating and total profit of $8,388. Grant income for the Healthy Kids program and administrative fees for claims processing and EDI services increased by $4.32 million, or 76.97%.

Nonoperating income

Interest income is derived from investments in Local Agency Investment Fund ("LAIF") and in other U.S. government agency securities. Yields on the LAIF increased during the reporting period from an average of .30% in 2015 to .43% in 2016. The Plan also accounts for the market value fluctuations on other investments due to overall changes in the general level of interest rates. This change in market value increased interest income by $308,114 during 2016. Nonoperating revenues (interest income) generated $805,530 in surplus in 2016.

Interest income is derived from investments in Local Agency Investment Fund ("LAIF") and in other U.S. government agency securities. Yields on the LAIF increased during the reporting period from an average of .25% in 2014 to .30% in 2015. The Plan also accounts for the market value fluctuations on other investments due to overall changes in the general level of interest rates. This change in market value decreased interest income by $285,361 during 2015. Nonoperating revenues (interest income) generated $497,416 in surplus in 2015.

Changes in Financial Position

	As of June 30			Net Change 2016 - 2015		Net Change 2015 - 2014	
Net Position	**2016**	**2015**	**2014**	**$**	**%**	**$**	**%**
Assets							
Cash and cash equivalents	$ 164,309,299	$ 97,560,561	$ 34,791,070	$ 66,748,738	68.42%	$ 62,769,491	180.42%
Healthy San Francisco restricted cash and cash equivalents	182,749,611	129,339,090	87,343,842	53,410,521	41.29%	41,995,248	48.08%
Investments	22,798,858	21,964,133	22,191,207	834,725	3.80%	(227,074)	-1.02%
Receivables & prepaid expenses	101,210,758	81,995,054	66,238,734	19,215,704	23.44%	15,756,320	23.79%
Capital assets, net of accumulated depreciation	9,091,201	10,741,410	6,577,986	(1,650,209)	-15.36%	4,163,424	63.29%
Restricted cash and cash equivalents	400,000	300,000	300,000	100,000	33.33%	-	0.00%
Total assets	480,559,727	341,900,248	217,442,839	138,659,479	40.56%	124,457,409	57.24%
Deferred outflows of resources	4,202,528	4,198,500	-	4,028	0.10%	4,198,500	100.00%
Total assets and deferred outflows of resources	$ 484,762,255	$ 346,098,748	$ 217,442,839	$ 138,663,507	40.06%	$ 128,655,909	59.17%
Total liabilities and deferred inflows of resources	$ 372,124,413	$ 263,384,419	$ 169,993,009	$ 108,739,994	41.29%	$ 93,391,410	54.94%
Net position							
Invested in capital assets	8,817,569	10,401,799	6,479,903	(1,584,230)	-15.23%	3,921,896	60.52%
Restricted - Knox-Keene	400,000	300,000	300,000	100,000	33.33%	-	0.00%
Unrestricted	103,420,273	72,012,530	40,669,927	31,407,743	43.61%	31,342,603	77.07%
Total net position	112,637,842	82,714,329	47,449,830	29,923,513	36.18%	35,264,499	74.32%
Total liabilities and net position	$ 484,762,255	$ 346,098,748	$ 217,442,839	$ 138,663,507	40.06%	$ 128,655,909	59.17%

Assets

Cash balances for the Plan as well as from Healthy San Francisco participants and employer deposits totaled $347.06 million at June 30, 2016. Cash has increased due to employer deposits for Healthy San Francisco and cash provided by operating activities.

Cash balances for the Plan as well as from Healthy San Francisco participants and employer deposits totaled $226.90 million at June 30, 2015. Cash has increased due to employer deposits for Healthy San Francisco and cash provided by operating activities.

Cash balances for the Plan as well as from Healthy San Francisco participants and employer deposits totaled $122.13 million at June 30, 2014. As yields in LAIF have declined, the Plan acquired $19.72 million in long-term and $2.47 million in short-term government agency and corporate bonds with a higher yield of 2.63%.

Liabilities

As of June 30, 2016, Healthy San Francisco liabilities to the Department of Public Health include $0 of earned premiums and $1.81 million in unearned (pre-paid) participant fees. Employer contributions directed to the MRA totaled $177.67 million. Capitation payable decreased in 2016 by $4.54 million due primarily to a decrease in provider MCE capitation rates and a decrease in the Healthy Workers membership. Medical claims payable increased by $375,604 in 2016. The Plan holds an additional $410,000 for a reserve margin and loss adjustment expense. The Plan also holds $7.38 million for a special medical loss ratio reserve related to the Medi-Cal expansion line of business which is included in payable to other governmental agencies**.** Amounts payable to governmental agencies increased by $62.25 million in 2016. This increase is due to $79.45 million in overpayments from DHCS related to the Medi-Cal Expansion population offset by Intergovernmental Transfer (IGT) payments made to providers during the year. Recent reductions in the MCE premium rate are awaiting CMS approval. Until CMS approval is received, DHCS must continue to pay the Plan using the most recently approved rate. The Plan has recorded revenue using the anticipated final rate and recorded a liability for the excess payment received. The excess funds will be recovered by the State once the final CMS approved rate is implemented.

As of June 30, 2015, Healthy San Francisco liabilities to the Department of Public Health include $444,488 of earned premiums and $1.78 million in unearned (pre-paid) participant fees. Employer contributions directed to the MRA totaled $124.43 million and another $4.80 million due to the Department of Public Health in 2015. Capitation payable increased in 2015 by $10.00 million due primarily to increasing membership for the first full year of the MCE population, other Medi-Cal and Healthy Workers membership growth and increases to the Practice Improvement Program. Medical claims payable increased by $616,359 in 2015. The Plan holds an additional $410,000 for a reserve margin and loss adjustment expense. The Plan also holds a $7.38 million for a special medical loss ratio reserve related to the Medi-Cal expansion line of business which is included in payable to other governmental agencies.

As of June 30, 2014, Healthy San Francisco liabilities to the Department of Public Health include $834,486 of earned premiums and $2.18 million in unearned (pre-paid) participant fees. Employer contributions directed to the MRA totaled $78.94 million and another $7.39 million due to the Department of Public Health in 2014. Capitation payable increased in 2014 by $22.14 million due primarily to the MCE population, other Medi-Cal and Healthy Workers membership growth and increases to the Practice Improvement Program. Medical claims payable increased by $1.17 million in 2014. The Plan holds an additional $410,000 for a reserve margin and loss adjustment expense. The Plan also holds a $4.74 million for a special medical loss ratio reserve related to the Medi-Cal expansion line of business which is included in payable to other governmental agencies.

Request for Information

Please direct questions concerning this report to:

Chief Financial Officer
San Francisco Health Plan
50 Beale Street, 12th Floor
San Francisco, CA 94105

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

To the Governing Board
San Francisco Health Authority and San Francisco Community Health Authority

Report on the Combined Financial Statements

We have audited the accompanying combined statements of net position of San Francisco Health Authority and the San Francisco Community Health Authority (collectively the "Plan"), as of June 30, 2016 and 2015, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined net position of San Francisco Health Authority and the San Francisco Community Health Authority, as of June 30, 2016 and 2015, and the combined results in its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 6, supplementary schedule of proportionate share of the net pension liability and supplementary schedule of contributions on pages 29 through 30 are not a required part of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Plan's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

San Francisco, California
October 21, 2016

COMBINED FINANCIAL STATEMENTS

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SAN FRANCISCO HEALTH AUTHORITY AND
SAN FRANCISCO COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF NET POSITION
June 30, 2016 and 2015

	2016	2015
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
CURRENT ASSETS		
Cash and cash equivalents	$ 164,309,299	$ 97,560,561
Healthy San Francisco restricted cash and cash equivalents	182,749,611	129,339,090
Short-term investments	1,979,074	4,809,671
Capitation receivables	84,197,621	68,831,083
Healthy San Francisco receivables	9,331,952	9,759,743
Other receivables	5,477,292	1,249,485
Prepaid expenses	2,203,893	2,154,743
Total current assets	450,248,742	313,704,376
Investments	20,819,784	17,154,462
Capital assets, net of accumulated depreciation	9,091,201	10,741,410
Restricted cash and cash equivalents	400,000	300,000
Total assets	480,559,727	341,900,248
Deferred outflows of resources	4,202,528	4,198,500
Total assets and deferred outflows of resources	$ 484,762,255	$ 346,098,748
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Accrued salaries and benefits	$ 5,345,983	$ 5,360,752
Healthy San Francisco accounts payable	185,988,931	133,757,077
Accounts payable and accrued expenses	19,675,615	21,452,940
Payable to other governmental agencies	97,163,543	34,910,441
Capitation payable	49,702,095	54,242,744
Medical claims payable	7,187,892	6,812,288
Current portion of capital lease obligations	88,498	79,338
Healthy Kids advanced premium	1,774,888	1,811,909
Total current liabilities	366,927,445	258,427,489
Capital lease obligations, net of current portion	185,134	260,273
Net pension liability	162,595	3,015,009
Total liabilities	367,275,174	261,702,771
Deferred inflows of resources	4,849,239	1,681,648
NET POSITION		
Invested in capital assets, net of related debt	8,817,569	10,401,799
Restricted:		
Required by legislative authority	400,000	300,000
Unrestricted	103,420,273	72,012,530
Total net position	112,637,842	82,714,329
Total liabilities, deferred inflows of resources, and net position	$ 484,762,255	$ 346,098,748

See accompanying notes.

SAN FRANCISCO HEALTH AUTHORITY AND
SAN FRANCISCO COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
Years Ended June 30, 2016 and 2015

	2016	2015
OPERATING REVENUES		
Capitation	$ 597,541,867	$ 570,029,033
Other income	8,814,830	8,873,100
Healthy San Francisco administration fee	6,092,632	5,364,768
Grants	1,170,279	1,066,300
Premium tax	(24,788,920)	(24,913,492)
Total revenues	588,830,688	560,419,709
OPERATING EXPENSES		
Medical	510,858,596	477,781,679
Salaries and benefits	20,703,433	20,581,258
Legal and professional	7,950,151	6,433,623
Other administrative	5,113,865	5,788,531
Healthy San Francisco expenses	6,090,964	5,356,380
Office expenses	2,325,387	2,306,456
Depreciation and amortization	1,933,542	2,218,979
Occupancy	3,611,539	1,450,810
Marketing and promotion	893,609	1,045,797
Insurance	231,619	169,195
Total expenses	559,712,705	523,132,708
Operating income	29,117,983	37,287,001
NONOPERATING REVENUES		
Interest income	805,530	497,416
Change in net position	29,923,513	37,784,417
TOTAL NET POSITION, beginning	82,714,329	44,929,912
TOTAL NET POSITION, ending	$ 112,637,842	$ 82,714,329

See accompanying notes.

SAN FRANCISCO HEALTH AUTHORITY AND
SAN FRANCISCO COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF CASH FLOWS
Years Ended June 30, 2016 and 2015

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums received	$ 631,917,220	$ 559,467,722
Healthy San Francisco premiums received and held	46,139,223	37,069,651
Medical expenses paid	(525,961,180)	(471,892,319)
Administrative expenses paid	(31,457,497)	(14,482,827)
Net cash provided by operating activities	120,637,766	110,162,227
CASH FLOWS FROM CAPITAL FINANCING AND RELATED ACTIVITIES		
Payments for purchase of capital assets	(266,927)	(6,036,393)
Principal payments on capital lease obligations	(82,385)	(85,585)
Net cash used in capital financing and related activities	(349,312)	(6,121,978)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of investment securities	(17,333,471)	(7,415,231)
Proceeds from sale and maturities of investments	16,498,746	7,642,305
Change in restricted cash and cash equivalents	(100,000)	-
Interest on investments	805,530	497,416
Net cash (used in) provided by investing activities	(129,195)	724,490
Net change in cash and cash equivalents	120,159,259	104,764,739
CASH AND CASH EQUIVALENTS (including Healthy San Francisco restricted cash and cash equivalents), beginning of year	226,899,651	122,134,912
CASH AND CASH EQUIVALENTS (including Healthy San Francisco restricted cash and cash equivalents), end of year	$ 347,058,910	$ 226,899,651
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 29,117,983	$ 37,287,001
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation and amortization	1,933,542	2,218,979
Gain on extinguishment of capital leases	-	(18,897)
(Increase) decrease in assets		
Capitation receivables	(15,366,538)	(11,089,878)
Healthy San Francisco receivables	427,791	(4,419,949)
Other receivables	(4,227,807)	(110,722)
Prepaid expenses	(49,150)	(135,771)
Increase (decrease) in liabilities		
Accrued salaries and benefits	(14,769)	1,734,017
Healthy San Francisco accounts payable	52,231,854	42,342,783
Accounts payable and accrued expenses	(1,777,325)	16,346,272
Payable to other governmental agencies	62,253,102	17,404,593
Capitation payable	(4,540,649)	10,002,422
Medical claims payable	375,604	616,359
Healthy Kids advanced premium	(37,021)	6,779
Net pension liability	311,149	(2,021,761)
Net cash provided by operating activities	$ 120,637,766	$ 110,162,227
SUPPLEMENTAL CASH FLOW DISCLOSURE		
Cash paid during the year for:		
Interest	$ 277,491	$ 5,918
Premium tax	$ 24,788,920	$ 24,913,492
Noncash transaction:		
Acquisition of equipment financed with capital leases	$ 16,406	$ 346,010

See accompanying notes.

NOTE 1 – DESCRIPTION OF ORGANIZATION

The San Francisco Health Authority and San Francisco Community Health Authority (collectively the "Plan"), is a public Health Maintenance Organization ("HMO") that is licensed by the State of California and located in the County of San Francisco (the "County"), California. San Francisco Health Plan's legal name is San Francisco Health Authority. However, it has operated since its inception as San Francisco Health Plan. The mission and purpose of San Francisco Health Plan are to develop, govern, and administer a comprehensive, integrated, competitive, and cost-efficient health care delivery system that will deliver quality health care to the Medi-Cal population in the County and to other populations in the County. To ensure quality and continuity of care, the San Francisco Health Plan, to the extent feasible, incorporates traditional safety net providers.

The San Francisco Health Authority was established by the County Board of Supervisors on December 15, 1994, in accordance with the State of California (the "State") Welfare and Institutions Code Section 14087.54 (the "Code") and is considered to be a public entity as defined under the State's Welfare and Institutions Code. This legislation provides that the San Francisco Health Authority is a legal entity, separate and apart from the County, and is not considered to be an agency, division, department, or instrumentality of the County. Further, the San Francisco Health Authority is not governed by, nor is subject to, the Charter of the County and is not subject to the County's policies or operational rules. The Plan became fully operational on January 1, 1997.

Effective July 1, 2005, the San Francisco Health Authority and the City and County of San Francisco entered into a Joint Powers Agreement to create the San Francisco Community Health Authority ("SFCHA") pursuant to Chapter 5, Division 7, Title 1 of the California Government Code. SFCHA serves as a Knox-Keene licensed health care service plan and enrolls members in the Healthy Families, Healthy Workers, and Healthy Kids programs, and any members in new programs that may be developed. The Young Adults portion of the Healthy Kids program was discontinued effective July 1, 2009. The Healthy Families program moved to Medi-Cal effective January 1, 2013. All programs will operate under the auspices of the Plan and the governing body and officers of the San Francisco Health Authority shall be the governing body and officers, respectively, of SFCHA.

Effective July 1, 2007, the San Francisco Department of Public Health began enrolling participants in Healthy San Francisco ("HSF"), a program for uninsured residents of San Francisco who are under 300% of the Federal Poverty Level ("FPL"). The HSF program is not health insurance. San Francisco Health Plan provides administrative services, including fee billing to participants over 100% of the FPL. In addition, effective January 2, 2008, employers have the option of providing health care coverage to their employees or be subject to a spending requirement and the option to participate in HSF. San Francisco Health Plan receives employer payments and establishes Medical Reimbursement Accounts ("MRA") for qualifying employees.

Effective July 1, 2013 through June 30, 2016, a sales tax is in effect, administered by the California Board of Equalization. The amount is determined by multiplying the Plan's capitation revenue by 3.9375%. The premium tax is recognized in the period the related capitation revenue is recognized. On March 1, 2016, Senate Bill ("SB") X2-2 established a new managed care organization provider tax, to be administered by the Department of Health Care Services ("DHCS"), effective July 1, 2016 through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined.

On September 8, 2010, the California State Legislature ratified the AB No. 1653 ("AB 1653"), which established a Quality Assurance Fee ("QAF") program allowing additional draw down federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the California Welfare and Institutions ("W&I") Code Section 14167.6 (a), DHCS shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with QAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services"; and, Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011 California approved SB 90, which extended the QAF through June 30, 2011. SB 335, signed into law in September of 2011, extended the QAF portion of SB 90 for an additional 30 months through December 31, 2013. SB 239, signed into law in October of 2013, extended the HQAF portion of SB 90 for an additional 36 months through December 31, 2016.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Accounting standards – Pursuant to Governmental Accounting Standards Board ("GASB") Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Plan's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

Proprietary fund accounting – The Plan uses the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and combined financial statements are prepared using the economic resources measurement focus.

Basis of combination – The accompanying combined financial statements as of June 30, 2016 and 2015, and the years then ended include the San Francisco Health Plan and San Francisco Community Health Authority. All intercompany balances have been eliminated in the combination.

Use of estimates – The preparation of the combined financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Capitation receivable, liability for incurred but not reported claims expense, net pension liability, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – Cash and cash equivalents consist of demand deposits and other short-term, highly liquid securities with original maturities of three months or less.

Amounts invested in the County Treasurer's investment pool (the "Investment Pool") are considered as cash and cash equivalents, because funds can be withdrawn by the Plan on demand. The County's Investment Oversight Committee Board has oversight responsibility for the Investment Pool. The Investment Pool is not SEC-registered, and based on the California statutes and the County's investment policy, primarily invests in obligation of U.S. Treasury, certain federal agencies, bankers' acceptances, commercial papers, certificates of deposit, repurchase agreements, and California State Treasurer's Local Agency Investment Fund ("LAIF"). The amounts invested in the Investment Pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the Investment Pool is generally based on published market prices and quotations from major investment firms. Because the Plan does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these cash and cash equivalents are not individually identifiable and were not required to be categorized under GASB Codification Section C20, *Cash Deposits with Financial Institutions,* Section I50, *Investments*, and Section I55, *Investments—Reverse Repurchase Agreements*. The fair value of the Plan's share in the pool approximated the fair value of the position in the pool at June 30, 2016 and 2015.

Restricted cash and cash equivalents – The Plan is required by the California Department of Managed Health Care ("DMHC") to restrict cash having a fair value of at least $300,000 for the payment of member claims in the event of its insolvency. The amounts recorded were $400,000 and $300,000 at June 30, 2016 and 2015, respectively. Restricted cash is composed of certificates of deposit and is stated at fair value.

Healthy San Francisco restricted cash and cash equivalents – The Plan is required to maintain cash balances for the HSF program on behalf of the San Francisco Department of Public Health. The Plan receives employer payments and establishes MRA's for qualifying employees. These amounts cannot be used by the Plan for its operations. The HSF restricted cash and cash equivalents consist of demand deposits.

Concentration of credit risk – Financial instruments potentially subjecting the Plan to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation ("FDIC") insurance thresholds. The Plan maintains its cash in bank deposit accounts, which, at times, may exceed FDIC insurance thresholds. The Plan believes no significant concentration of credit risk exists with these cash accounts.

The Plan is highly dependent upon the State of California for its revenues. A significant portion of accounts receivable and revenue are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the combined financial position of the Plan.

As of June 30, 2016 and 2015, the Plan had capitation receivables of $84,197,621 and $68,831,083, respectively, due from the State of California. For the years ended June 30, 2016 and 2015, the Plan recognized capitation revenues of $597,541,867 and $570,029,033, respectively, from the State of California.

Investments – All short-term and long-term investments consist of certificates of deposit, domestic corporate bonds, U.S. fixed income securities, municipal bonds, and foreign bonds. Investments are stated at fair market value as determined by quoted market prices, with any changes in the fair value reported on the combined statements of revenues, expenses, and changes in net position.

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Plan's California Public Employees' Retirement System ("CalPERS") plans ("pension plan") and additions to/deductions from the Pension Plans' fiduciary net position have been determined on the same basis as they are reported by CalPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Payables to other governmental agencies – As of June 30, 2016 and 2015, the Plan had $97,163,543 and $34,910,441, respectively in payables to other governmental agencies. This liability consists of $79,450,277 and $12,945,282 as of June 30, 2016 and 2015, respectively, in overpayments from DHCS related to the Medi-Cal Expansion population. DHCS continues to use the most recently approved MCE rate when making payment to the Plan each month. The final rate pending CMS approval will be less than the most recently approved rate. The Plan has been using the anticipated final rate to record revenue and recording a liability for the excess payment received. As of June 30, 2016, other amounts making up the remaining $17,713,266 include $7,376,087 in a special MCE medical loss ratio reserve, $5,574,175 in managed care tax and $4,763,004 in AB85 pass-through funds for San Francisco General Hospital. As of June 30, 2015, other amounts making up the remaining $21,965,159 include $7,376,087 in a special MCE medical loss ratio reserve, $11,373,370 in managed care tax, $2,600,121 in AB85 pass-through funds for San Francisco General Hospital, and $615,581 in SB 325, SB 208 and IGT provider payables.

Capital assets – Capital assets include furniture, equipment, computer hardware, computer software, leasehold improvements, and capital leases. Capital assets are recorded at cost. Depreciation of equipment, furniture, fixtures, computer hardware, computer software, leasehold improvements and capital leases is based on the straight-line method over the estimated useful lives of the assets, estimated to be three to ten years. Equipment under capital leases is amortized over the shorter of the estimated useful life or anticipated lease term. Such amortization expense is included in depreciation expense in the combined financial statements. The Plan capitalizes capital expenditures over $5,000, which will have a useful life of more than one year.

The Plan evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Net position – Net position is classified as invested in capital assets, net of related debt, restricted, or unrestricted net position. Invested in capital assets, net of related debt represents investments in equipment, furniture, fixtures, computer hardware, computer software, leasehold improvements and capital leases, net of depreciation and related debt. Restricted net position is noncapital assets that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to the Plan. Unrestricted net position consists of net position that does not meet the definition of invested in capital assets or restricted net position.

Operating revenues and expenses – The Plan's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting,* all operating revenues are considered program revenues because they are charges for services provided and program-specific operating grants. The primary operating expense is medical expenses. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Capitation revenue – Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the current Medi-Cal contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by California DHCS ("CDHCS") on a monthly basis in arrears based on eligible members and are adjusted for a maximum of twelve months of retroactivity. Adjustments to revenue due to changes in member eligibility are recognized on a current basis.

Effective with the enrollment of the Adult Expansion Population per the Affordable Care Act on January 1, 2014, the Plan is subject to CDHCS requirements to meet a minimum of 85% medical loss ratio for this population. Specifically, the Plan will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by CDHCS. In the event the Plan expends less than the 85% requirement, the Plan will be required to return to CDHCS the difference between the minimum threshold and the actual allowed medical expenses. The 85% MLR requirement is for January 2014 through June 2015, an 18-month period. For the year ended June 30, 2015, the last 12 months of the 18-month 85% MLR requirement period, the Plan has not met the minimum threshold and has recorded $7,376,087 contra-revenue and related payable to other governmental agencies. For the year ended June 30, 2016, the Plan has met the minimum MLR threshold of 85%.

Healthy Kids revenue is based on a contracted per-member, per-month premium and is recorded in the month in which eligible enrollees are entitled to health care services. Monthly premiums are billed one month in arrears. Premiums collected in advance are recorded as deferred revenue. Unearned income of $1,774,888 and $1,811,909 as of June 30, 2016 and 2015, respectively, is included in Healthy Kids advanced premiums on the combined statements of net position.

Premium deficiencies – The Plan performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2016 or 2015.

Grants – The Plan receives grant revenues, which are restricted as to their purpose by the grantor organizations. Revenues from such grants are recognized as operating revenue when all requirements have been met, as they are restricted for specific operating purposes of the Plan.

Healthy San Francisco administration fee – The Plan is reimbursed for operating expenses required to support the Healthy San Francisco program. The Plan bills the San Francisco Department of Public Health ("DPH") 6 monthly for the direct cost of personnel, space, supplies, and other expenses according to the administrative service agreement. Amounts due from DPH for administration fees are $6,092,632 and $5,364,768 at June 30, 2016 and 2015, respectively, and are included in Healthy San Francisco receivables.

Medical expenses – Hospital, physician, and other service costs are recognized in the period the services are provided and are based on actual paid claims plus an estimate for incurred, but not reported, claims. The estimate for reserves for claims is based on actuarial projections of hospital and other costs using historical analysis of claims paid and authorization and admission data. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Many physicians belonging to medical groups and certain hospitals are compensated primarily on a capitation basis with provisions for additional incentive payments in certain circumstances.

Insurance coverage – The Plan maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the claims-made policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the term of the claims-made policies but reported subsequent to the termination of the insurance contract may be uninsured. These policies were renewed subsequent to year-end. Physicians and hospitals, with whom the Plan contracts, are required to maintain their own malpractice coverage.

Income taxes – The Plan operates under the purview of the Internal Revenue Code, Section 501(a) and corresponding California Revenue and Taxation Code provisions. As such, the Plan is not subject to federal or state income taxes.

New accounting pronouncements – In February 2015, the GASB issued GASB Statement No. 72, *Fair Value Measurement and Application,* ("GASB 72") which is effective for financial statements for periods beginning after June 15, 2015. GASB 72 addresses accounting and financial reporting issues related to fair value measurements. This Statement also provides guidance for determining a fair value measurement for financial reporting purposes and provides guidance for applying fair value to certain investments and disclosures related to all fair value measurements. The Plan adopted this guidance for fiscal year 2016 and 2015. See Note 4.

In June 2015, the GASB issued GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments,* ("GASB 76") which is effective for financial statements for periods beginning after June 15, 2015. GASB 76 supersedes the requirements of GASB Statement No. 55, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*. GASB 76 reduces the GAAP hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and nonauthoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP. The Plan has adopted this standard in the June 30, 2016, financial statement. The adoption had no material impact to the combined financial statements for the fiscal year ended June 30, 2016.

In December 2015, the GASB issued Statement No. 79, *Certain External Investment Pools and Pool Participants* ("GASB 79"). This Statement addresses accounting and financial reporting for certain external investment pools and pool participants. Specifically, it establishes criteria for an external investment pool to qualify for making the election to measure all of its investments at amortized cost for financial reporting purposes. An external investment pool qualifies for that reporting if it meets all of the applicable criteria established in this Statement. The specific criteria address (1) how the external investment pool transacts with participants; (2) requirements for portfolio maturity, quality, diversification, and liquidity; and (3) calculation and requirements of a shadow price. Significant noncompliance prevents the external investment pool from measuring all of its investments at amortized cost for financial reporting purposes. Professional judgment is required to determine if instances of noncompliance with the criteria established by this Statement during the reporting period, individually or in the aggregate, were significant. The Plan has adopted this standard in the June 30, 2016 combined financial statements. There was no material impact on the application of GASB 79 for the fiscal year ended 2016.

In March 2016, the GASB issued GASB Statement No. 82, *Pension Issues*, ("GASB 82") which is effective for financial statements for periods beginning after June 15, 2017. GASB 82 improves financial reporting by enhancing consistency in the application of financial reporting requirements to certain pension issues. The Plan is reviewing the impact of the adoption of GASB 82 for the fiscal year ending June 30, 2018.

Reclassifications – Certain amounts in the 2015 combined financial statements have been reclassified to conform to the 2016 presentation.

NOTE 3 – CASH AND INVESTMENTS

Cash and investments as of June 30 consist of the following:

	2016	2015
Cash on hand	$ 1,000	$ 1,000
Cash deposits	347,057,910	226,898,651
Investments	23,198,858	22,264,133
Total cash and investments	$ 370,257,768	$ 249,163,784
Reconciliation to combined statements of net position:		
Cash and cash equivalents	$ 164,309,299	$ 97,560,561
Healthy San Francisco restricted cash and cash equivalents	182,749,611	129,339,090
Short-term investments	1,979,074	4,809,671
Investments	20,819,784	17,154,462
Restricted cash and cash equivalents	400,000	300,000
Total cash and investments	$ 370,257,768	$ 249,163,784

Included in the cash deposits balance as of June 30, 2016 and 2015, is $182,749,611 and $129,339,090, respectively, related to the Plan's HSF restricted cash and cash equivalents.

Included in the investments balance as of June 30, 2016 and 2015, is $400,000 and $300,000, respectively related to the Plan's Knox-Keene reserve requirement. This amount is included in restricted cash and cash equivalents in the combined statements of net position.

The Plan's Annual Investment Policy ("Policy") sets forth the guidelines for the investment of all operating funds. The Policy conforms to the California Investment Code §53646 ("Code") as well as customary standards of prudent investment management. The objectives of the Plan's investment policy, in order of priority, are safety of principal, maintenance of liquidity, and attainment of a market rate return that considers risk constraints and cash flow requirements. The policy also identifies certain provisions that address interest rate risk, credit risk, and concentration of risk.

Authorized Investment Type	Maximum Maturity	Maximum Specified Percentage Portfolio	Maximum Investment in One Issuer
Money Market	60 months	1	None
Mutual Funds	60 months	0.2	None
Bankers' Acceptances	270 days	0.4	30%
Commercial Paper	180 days	30%	10%
Negotiable Certificates of Deposits	2 years	0.3	None
Repurchase Agreements	10 days	0.3	None
U.S. Treasury Obligations	Each investment will not exceed a weighted-average maturity of 60 months, with no individual investment to exceed a maturity period of 84 months (seven years).	1	None
U.S. Agencies	Each investment will not exceed a weighted-average maturity of 60 months, with no individual investment to exceed a maturity period of 84 months (seven years).	1	None
State Operating Funds and Reserves	Each investment will not exceed a weighted-average maturity of 60 months, with no individual investment to exceed a maturity period of 84 months (seven years).	None	None

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, the Plan will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The California Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the State law. As of June 30, 2016 and 2015, deposits exposed to custodial credit risk because they were uninsured, and the collateral held by the pledging bank not in the Plan's name, were $347,058,910 and $226,899,651, respectively.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. In accordance with its Policy, the Plan manages the risk of market value fluctuations due to overall changes in the general level of interest rates by limiting the weighted-average maturity of its portfolio to no more than 60 months.

As of June 30, 2016:

Investment Type	Fair Value	Weighted-Average Maturity (Years)
Certificates of Deposit	$ 400,000	1.11
U.S. Agencies	22,119,358	3.0
Foreign Agencies	679,500	4.5
Total fair value	$ 23,198,858	
Portfolio weighted average maturity		3.1

As of June 30, 2015:

Investment Type	Fair Value	Weighted-Average Maturity (Years)
Certificates of Deposit	$ 300,000	0.4
U.S. Agencies	20,660,313	2.7
Foreign Agencies	1,303,820	2.7
Total fair value	$ 22,264,133	
Portfolio weighted average maturity		0.9

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. Per GASB Codification Section C20, *Cash Deposits with Financial Institutions,* Section I50, *Investments*, and Section I55, *Investments—Reverse Repurchase Agreements*, unless there is information to the contrary, obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government are not considered to have credit risk and do not require disclosure of credit quality. Presented below is the minimum rating required by (where applicable) the California Government Code or the Plan's policy and the actual rating as of year-end for each investment type.

Ratings as of June 30, 2016:

Investment Type	Fair Value	AAA	AA3	AA1	A-1	A-2	A-3	BAA1
Certificates of Deposit	$ 400,000	$ -	$ -	$ -	$ 400,000	$ -	$ -	$ -
U.S. Agencies	22,119,358	13,693,335	655,681	462,528	1,422,024	1,838,814	3,390,720	656,256
Foreign Agencies	679,500	-	-	-	679,500	-	-	-
Total fair value	$ 23,198,858	$ 13,693,335	$ 655,681	$ 462,528	$ 2,501,524	$ 1,838,814	$ 3,390,720	$ 656,256

Ratings as of June 30, 2015:

Investment Type	Fair Value	AAA	AA3	AA1	A-1	A-2	A-3	BAA1
Certificates of Deposit	$ 300,000	$ -	$ -	$ -	$ 300,000	$ -	$ -	$ -
U.S. Agencies	20,660,313	9,925,361	3,421,292	-	3,021,304	2,991,801	-	1,300,555
Foreign Agencies	1,303,820	-	648,889	-	654,931	-	-	-
Total fair value	$ 22,264,133	$ 9,925,361	$ 4,070,181	$ -	$ 3,976,235	$ 2,991,801	$ -	$ 1,300,555

Concentration of credit risk – The investment policy of the Plan contains certain limitations on the amount that can be invested in any one issuer and is listed in the table above. There were no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the Plan's total investments as of June 30, 2016 and 2015.

NOTE 4 – FAIR VALUE

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the statements of net position at June 30, 2016 and 2015, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Fixed income: Fixed income funds are valued at the net asset value of shares held by the Plan and are valued at the closing price reported on the active market on which the individual securities are traded.

The following tables present fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30:

Description	Level 1	Level 2	Level 3	2016
Fixed income				
U.S. government bonds & notes	$ -	$ 5,966,643	$ -	$ 5,966,643
U.S. agencies	-	7,480,539	-	7,480,539
Corporate bonds	5,402,276	-	-	5,402,276
Municipal bonds	-	1,613,414	-	1,613,414
Other	-	2,335,986	-	2,335,986
Total investments by fair value level	$ 5,402,276	$ 17,396,582	$ -	$ 22,798,858

Description	Level 1	Level 2	Level 3	2015
Fixed income				
U.S. government bonds & notes	$ -	$ 1,735,970	$ -	$ 1,735,970
U.S. agencies	-	8,907,131	-	8,907,131
Corporate bonds	4,499,845	-	-	4,499,845
Municipal bonds	-	4,856,256	-	4,856,256
Other	-	1,964,931	-	1,964,931
Total investments by fair value level	$ 4,499,845	$ 17,464,288	$ -	$ 21,964,133

Investments by fair value consist of the following at June 30:

	2016	2015
Short-term investments	$ 1,979,074	$ 4,809,671
Investments	20,819,784	17,154,462
Total	$ 22,798,858	$ 21,964,133

NOTE 5 – CAPITAL ASSET

Capital asset balances as of June 30 consist of the following:

	2016				
	Balance at July 1, 2015	Increases	Decreases	Transfers	Balance at June 30, 2016
Furniture and equipment	$ 2,097,260	$ -	$ -	$ -	$ 2,097,260
Computer hardware	1,936,343	80,373	-	-	2,016,716
Computer software	6,928,252	369,000	-	-	7,297,252
Leasehold improvements	1,897,741	-	(182,446)	-	1,715,295
Equipment under capital lease	346,010	16,406	-	-	362,416
	13,205,606	465,779	(182,446)	-	13,488,939
Less accumulated depreciation for:					
Capital assets	(2,453,508)	(1,818,176)	-	-	(4,271,684)
Equipment under capital lease	(10,688)	(115,366)	-	-	(126,054)
	(2,464,196)	(1,933,542)	-	-	(4,397,738)
Net capital assets	$ 10,741,410	$ (1,467,763)	$ (182,446)	$ -	$ 9,091,201

	2015				
	Balance at July 1, 2014	Increases	Decreases	Transfers	Balance at June 30, 2015
Furniture and equipment	$ 2,676,020	$ 2,097,260	$ (2,676,020)	$ -	$ 2,097,260
Computer hardware	3,652,731	1,936,343	(3,652,731)	-	1,936,343
Computer software	9,345,780	105,049	(2,522,577)	-	6,928,252
Leasehold improvements	1,517,418	1,897,741	(1,517,418)	-	1,897,741
Equipment under capital lease	354,133	346,010	(354,133)	-	346,010
	17,546,082	6,382,403	(10,722,879)	-	13,205,606
Less accumulated depreciation for:					
Capital assets	(10,667,662)	(2,182,928)	10,397,082	-	(2,453,508)
Equipment under capital lease	(300,434)	(36,051)	325,797	-	(10,688)
	(10,968,096)	(2,218,979)	10,722,879	-	(2,464,196)
Net capital assets	$ 6,577,986	$ 4,163,424	$ -	$ -	$ 10,741,410

NOTE 6 – CAPITATION PAYABLE

Capitation payable represents premiums from CDHCS, Managed Risk Medical Insurance Board ("MRMIB"), and the In Home Supportive Service ("IHSS") Public Authority to be paid to medical providers for services rendered to eligible members. Capitation payable as of June 30, 2016 and 2015, was $49,702,095 and $54,242,744, respectively. Capitation payable represents capitation payments due to providers under the Medi-Cal, Healthy Workers, and Healthy Kids programs of the Plan, for the months of June 2016 and 2015, respectively. Included in the capitation payable balance at June 30, 2016 and 2015, is $207,395 and $1,800,000, respectively in Medi-Cal funding made available through special compensation provisions within the Affordable Care Act ("ACA"). These funds will be distributed to providers who render qualifying services as outlined within the ACA.

NOTE 7 – MEDICAL CLAIMS PAYABLE

The Plan contracts with various providers, including physicians and hospitals, to provide certain health care products and services to enrolled Medi-Cal, Healthy Families, Healthy Workers, and Healthy Kids beneficiaries. The cost of the health care products and services provided or contracted for is accrued in the period in which it is provided to a member and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on projections of hospital and other costs using historical studies of claims paid. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

For the years ended June 30, 2016 and 2015, the following is a reconciliation of the medical claims payable liability and the reserve for future claims losses:

	2016	2015
Balance, July 1	$ 6,812,288	$ 6,195,929
Add: claims expenses incurred	34,199,756	29,044,570
Less: claims expenses paid	(33,824,152)	(28,428,211)
Balance, June 30	$ 7,187,892	$ 6,812,288

NOTE 8 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

The Plan has entered into certain reinsurance ("stop-loss") agreements with third parties to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Plan certain proportions of the cost of each member's annual hospital services, in excess of specified deductibles, no more than $1,000,000 in aggregate over all contract years per member. Stop-loss insurance premiums of $1,778,134 and $1,273,467 are included in medical expense in 2016 and 2015, respectively. Stop-loss insurance recoveries were $2,791 and $784,925 in 2016 and 2015, respectively, and included certain amounts passed through to providers. Stop-loss insurance recoveries are recorded as an offset to stop-loss insurance expense included in other income in 2016 and 2015, respectively.

NOTE 9 – RETIREMENT, DEFERRED COMPENSATION, AND DEFINED CONTRIBUTION PLANS

Plan description – Effective May 3, 1999, the Plan joined the California Public Employees Retirement System ("CalPERS"), a cost-sharing multiple-employer defined benefit pension plan ("pension plan"). CalPERS provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to CalPERS members and beneficiaries. CalPERS acts as a common investment and administrative agent for participating public entities within the State of California. Benefit provisions and all other requirements are established by state statute. Copies of the CalPERS annual financial report may be obtained from their Executive Office: 400 P Street, Sacramento, California 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: the Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for each plan are applied as specified by the Public Employees' Retirement Law.

The pension plan's provisions and benefits in effect at June 30, 2016, are summarized as follows:

	Hire date prior to January 1, 2013	Hire date on or after January 1, 2013
Benefit formula	2.7% @ 55	2% @ 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50-55	52
Monthly benefits, as a % of eligible compensation	monthly for life	monthly for life
Required employee contributions rates	7.00%	6.25%
Required employer contributions rates	11.03%	6.25%

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. Funding contributions for both Pension Plans are determined annually on an actuarial basis as of June 30 by CalPERS. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The Plan is required to contribute the difference between the actuarially determined rate and the contribution rate of employees.

For the year ended June 30, 2016, the employer contributions recognized as part of pension expense was $4,198,500 and employee contributions was $1,680,963.

For the year ended June 30, 2015, the employer contributions recognized as part of pension expense was $1,599,668 and employee contributions was $1,441,994.

As of June 30, 2016 and 2015, the Plan reported $162,595 and $3,015,009, respectively, of net pension liabilities for its proportionate shares of the net pension liability of the pension plan.

The Plan's net pension liability for the pension plan is measured as the proportionate share of the net pension liability. For the fiscal year ended June 30, 2016 and 2015, the net pension liability of the pension plan is measured as of June 30, 2015 and 2014, respectively, and the total pension liability for the pension plan used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2014 and 2013, respectively, rolled forward to June 30, 2015 and 2014, respectively, using standard update procedures. The Plan's proportion of the net pension liability was based on a projection of the Plan's long-term share of contributions to the pension plans relative to the projected contributions of all participating employers, actuarially determined. The Plan's proportionate share of the net pension liability for the pension plan as of June 30, 2016 and 2015, was 0.00593% and 0.04845%, respectively.

For the year ended June 30, 2016 and 2015, the Plan recognized pension expense of $878,302 and $2,575,614, respectively, as included in salaries and benefits in the combined statements of revenue, expenses and changes in net position. At June 30, 2016, the Plan reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Net difference between expected and actual earnings on pension plan investments	$ -	$ (598,101)
Changes in assumptions	-	(1,193,070)
Difference in actual and projected contributions	799,017	-
Difference between expected and actual experiences	264,893	-
Adjustments due to differences in proportions	1,129,265	(1,048,715)
Total	$ 2,193,175	$ (2,839,886)

At June 30, 2015, the Plan reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Pension contributions subsequent to measurement date	$ 4,597,375	$ -
Difference between expected and actual earnings on pension plan investments	-	(1,013,183)
Adjustments due to differences in proportions	-	(668,465)
Change in employer's proportion and differences between the employer's contributions and the employer's proportionate share of contributions	(398,875)	-
Total	$ 4,198,500	$ (1,681,648)

The Plan also reported $1,776,661 and $4,597,375 as deferred outflows of resources related to contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2016 and 2015, respectively. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Fiscal Year Ended,	
2016	$ (556,829)
2017	(509,083)
2018	(345,316)
2019	764,517
2020	-
	$ (646,711)

Actuarial assumptions – The total pension liabilities in the June 30, 2014 actuarial valuations were determined using the following actuarial assumptions:

Valuation date	June 30, 2014
Measurement date	June 30, 2015
Actuarial cost method	Entry age normal cost method
Actuarial assumptions	
Discount rate	7.65%
Inflation	2.75%
Payroll growth	3.00%
Projected salary increase	Varies by entry age and service
Investment rate of return	7.65%
Mortality rate table	Derived using CalPERS' membership data for all funds

The underlying mortality assumptions and all other actuarial assumptions used in the June 30, 2014, valuation were based on the results of a January 2015 actuarial experience study for the period 1997 to 2011. Further details of the Experience Study can found on the CalPERS website.

The total pension liabilities in the June 30, 2013, actuarial valuations were determined using the following actuarial assumptions:

Valuation date	June 30, 2013
Measurement date	June 30, 2014
Actuarial cost method	Entry age normal cost method
Actuarial assumptions	
Discount rate	7.50%
Inflation	2.75%
Payroll growth	3.00%
Projected salary increase	Varies by entry age and service
Investment rate of return	7.50%
Mortality rate table	Derived using CalPERS' membership data for all funds

Discount rate – The discount rate used to measure the total pension liability was 7.65% and 7.50% as of the fiscal year ended June 30, 2016 and 2015, respectively, for each Pension Plan. The discount rate was changed from 7.5 percent (net of administrative expense) to 7.65 percent to correct for an adjustment to exclude administrative expense.

Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.50 percent discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 7.50 percent will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report that can be obtained from the CalPERS website.

According to Paragraph 30 of GASB No. 68, the long-term discount rate should be determined without reduction for pension plan administrative expense. The 7.50 percent investment return assumption used in this accounting valuation is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 7.65 percent. Using this lower discount rate has resulted in a slightly higher Total Pension Liability and Net Pension Liability. CalPERS checked the materiality threshold for the difference in calculation and did not find it to be a material difference.

CalPERS is scheduled to review all actuarial assumptions as part of its regular Asset Liability Management ("ALM") review cycle that is scheduled to be completed in February 2018. Any changes to the discount rate will require Board action and proper stakeholder outreach. For these reasons, CalPERS expects to continue using a discount rate net of administrative expenses for GASB 67 and 68 calculations through at least the 2017-18 fiscal year. CalPERS will continue to check the materiality of the difference in calculation until such time as we have changed our methodology.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	New Strategic Allocation	Real Return Years 1-10 (a)	Real Return Years 11+ (b)
Global equity	51.0%	5.25%	5.71%
Global fixed income	19.0%	0.99%	2.43%
Inflation sensitive	6.0%	0.45%	3.36%
Private equity	10.0%	6.83%	6.95%
Real estate	10.0%	4.50%	5.13%
Infrastructure and forestland	2.0%	4.50%	5.09%
Liquidity	2.0%	-0.55%	-1.05%

(a) An expected inflation rate of 2.5% was used for this period
(b) An expected inflation rate of 3.0% was used for this period

Sensitivity of the proportionate share of the Net Pension Liability to changes in the discount rate – The following presents the Plan's proportionate share of the net pension liability for each Pension Plan, calculated using the discount rate for each Pension Plan, as well as what the Plan's proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate as of June 30:

2016	1% Decrease (6.65%)	Current Discount Rate (7.65%)	1% Increase (8.65%)
Net pension liability	$ 272,683	$ 162,595	$ 71,704

2015	1% Decrease (6.50%)	Current Discount Rate (7.50%)	1% Increase (8.50%)
Net pension liability	$ 5,371,814	$ 3,015,009	$ 1,059,085

Pension plan fiduciary net position – Detailed information about each pension plan's fiduciary net position is available in the separately issued CalPERS financial reports.

Payable to the pension plan – At June 30, 2016, the Plan reported a payable of $162,595 for the outstanding amount of contributions to the pension plan required for the year ended June 30, 2016. At June 30, 2015, the Plan reported a payable of $3,015,009 for the outstanding amount of contributions to the pension plan required for the year ended June 30, 2015.

Deferred compensation plan – The Plan offers its employees a deferred compensation plan with CalPERS created in accordance with Internal Revenue Code Section 457. The deferred compensation plan is available to all employees and permits them to defer a portion of their salary. No employer contribution to the plan is required. Deferred compensation is not available to employees until termination, retirement, death, or an unforeseeable emergency.

Defined contribution retirement plan – A defined contribution retirement plan (IRS 401a), was implemented effective October 1, 2013. In 2016 and 2015, the Plan contributed approximately $1,422,014 and $915,189, respectively to the defined contribution retirement plan.

Employees of the Plan are eligible to participate in the defined contribution retirement plan upon date of hire. The Plan will make contributions in an amount equal to each participant's compensation times an applicable contribution rate as set by the Plan. Participants are fully vested upon completing three years of service. Members of the Executive team are required to make pretax contributions into the defined contribution retirement plan.

NOTE 10 – OPERATING LEASE

The Plan executed a 10-year lease on office space on August 15, 2005, which expired in the current fiscal year and replaced with a 10-year and 4-month lease on office space, executed on June 20, 2014. The lease commenced on July 1, 2015. The terms of the lease agreement require a standby Letter of Credit for the purposes of collateralizing the agreement. This new lease covers approximately 57,400 square feet of office space located at 50 Beale Street in San Francisco. The lease runs through October 31, 2025.

Total rental expense for the years ended June 30, 2016 and 2015, was $3,927,284 and $1,384,545, respectively. Rent expense related to the Plan for the years ended June 30, 2016 and 2015, was $3,537,616 and $1,211,884, respectively, and is included in occupancy. Rent expense related to HSF for the years ended June 30, 2016 and 2015, was $389,668 and $172,661, respectively and is included in Healthy San Francisco expenses

Future minimum lease obligations consist of the following:

Fiscal Year Ended,	
2017	$ 3,624,029
2018	3,730,403
2019	3,839,624
2020	3,951,776
2021	4,066,949
Thereafter	16,776,980
	$ 35,989,761

The Plan records minimum base rent on a straight-line basis over the life of the lease term and, accordingly, has recorded a deferred rent liability, included in accounts payable and accrued expenses of $1,550,605 and $0, as of June 30, 2016 and 2015, respectively.

NOTE 11 – CAPITAL LEASES

The Plan leases copier machines under capital lease obligations. These lease agreements require monthly payments of $8,837 and expire in 2019. A summary of capital lease obligations at June 30 is as follows:

	2016	**2015**
Capital lease obligations, at implicit rate ranging from 7% to 10%, collateralized by leased equipment.	$ 273,632	$ 339,611
Less: current portion	(88,498)	(79,338)
Capital lease obligations, net of current portion	$ 185,134	$ 260,273

Scheduled principal payments on capital lease obligations at June 30 are as follows:

2017	$ 102,509
2018	102,509
2019	93,934
Total minimum lease payments	298,952
Less: amounts representing interest	(25,320)
	$ 273,632

A schedule of changes in the Plan's capital lease obligations for the year ended June 30, 2016, is as follows:

	June 30, 2015	Additions	Reductions	June 30, 2016
Capital leases - equipment	$ 339,611	$ 16,406	$ (82,385)	$ 273,632
Total	$ 339,611	$ 16,406	$ (82,385)	$ 273,632

A schedule of changes in the Plan's capital lease obligations for the year ended June 30, 2015, is as follows:

	June 30, 2014	Additions	Reductions	June 30, 2015
Capital leases - equipment	$ 98,083	$ 346,010	$ (104,482)	$ 339,611
Total	$ 98,083	$ 346,010	$ (104,482)	$ 339,611

Equipment held under capital lease obligations included in capital assets is as follows:

	2016	2015
Equipment	$ 346,010	$ 346,010
Less: accumulated amortization	(126,054)	(10,688)
Equipment held under capital lease obligations, net	$ 219,956	$ 335,322

NOTE 12 – TANGIBLE NET EQUITY

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975 (the "Act"), the Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity level was approximately $10,744,461 and $7,573,008 at June 30, 2016 and 2015, respectively. The Plan's tangible net equity was $112,637,842 and $82,714,329 at June 30, 2016 and 2015, respectively.

NOTE 13 – RISK MANAGEMENT

The Plan is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Plan carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Plan's commercial coverage.

NOTE 14 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the Plan is a party to claims and legal actions by enrollees, providers, and others. The Plan's policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, the Plan's management is of the opinion that any liability that may ultimately result in claims or legal actions will not have a material effect on the combined financial position or results of operations of the Plan.

In September 2014, the Plan increased its revolving line of credit to $40,000,000. The line of credit carries an interest rate of the greater of 2.25%, or LIBOR, plus 2%. The expected to maturity was extended to February 28, 2017, and is in the process of being extended and/or renewed.

As of June 30, 2016 and 2015, the Plan had no balance outstanding under its revolving line of credit of $40,000,000.

NOTE 15 – HEALTH CARE REFORM

In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transforms the U.S. healthcare system and increases regulations within the U.S. health insurance industry. This legislation is intended to expand the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that take effect from 2010 through 2018, with most measures effective in 2014. Under the Healthcare Reform Legislation, Medi-Cal coverage expanded as of January 2014 for low-income families, children, pregnant women, seniors, and persons with disabilities. For the years ending June 30, 2016 and 2015, the Plan served a total of 649,378 and 484,353 Medi-Cal Expansion member months, with increased revenues by approximately $251,084,966 and $257,502,194, respectively.

SUPPLEMENTARY INFORMATION

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SAN FRANCISCO HEALTH AUTHORITY AND
SAN FRANCISCO COMMUNITY HEALTH AUTHORITY
SCHEDULE OF PROPORTIONATE SHARE OF THE NET PENSION LIABILITY

	2016	2015
Proportion of the net pension liability	0.00237%	0.04845%
Proportionate share of the net pension liability	$ 162,595	$ 3,015,009
Covered - employee payroll	$ 23,622,637	$ 16,556,028
Proportionate share of the net pension liability as percentage of covered-employee payroll	0.69%	18.21%
Plan's fiduciary net position	$ 20,420,371	$ 14,750,376
Plan fiduciary net position as a percentage of the total pension liability	99.21%	83.03%

	2016	2015
Measurement period	2014-2015	2013-2014
Actuarially determined contribution	$ 1,790,738	$ 1,675,645
Contributions in relation to the actuarially determined contribution	(1,790,738)	(1,675,645)
Contribution deficiency (excess)	$ -	$ -
Covered-employee payroll	$ 23,622,637	$ 16,556,028
Contributions as a percentage of covered-employee payroll	7.58%	10.12%

Agenda Item 3:
Action Item

- Review and Approval of Unaudited Monthly Financial Statements and Investment Reports

SAN FRANCISCO HEALTH PLAN™
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September 2016 Financial Statement Summary

September 2016 shows an overall surplus of $1,108,000 which is $272,000 below budget:

- $927,000 decrease in Professional medical expenses due to a reduction of the July and August PIP accruals. Excluding this adjustment, the Plan had a surplus of $181,000.
- $792,000 decrease in Hepatitis C revenue accrual due to a decrease in the kick payment. The 23.4% reduction in the Hepatitis C kick payment effective July 2016 is making it difficult for the Plan to achieve its budget projections.

Other significant events recorded during September 2016 include:

- 8% capitation rate reduction for the Adult Expansion (MCE) category effective July 2016.
- Continuation of paying AIDS capitation to Providers. AIDS categories of aid were eliminated effective July 1, 2016.

	PROFIT/LOSS					
	----------SEP 2016----------					
	----------MONTH----------			----------YTD----------		
	ACTUAL	BUDGET	FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)
FROM OPERATIONS (LOSS)	$ 1,059,370	$ 1,322,066	$ (262,696)	$ 1,072,679	$ 4,359,665	$ (3,286,986)
INTEREST/INVESTMENT CHANGE	$ 48,502	$ 58,000	$ (9,498)	$ 78,058	$ 174,000	$ (95,942)
NET SURPLUS (LOSS)	$ 1,107,872	$ 1,380,066	$ (272,194)	$ 1,150,737	$ 4,533,665	$ (3,382,928)

Overall premium revenue came in at $46,221,000 versus a budget of $52,175,000. This decrease is driven by:

- $3,834,000 less in Hepatitis C revenue due to a 23.4% rate reduction in the kick payment.
- $809,000 less in MCE premium revenue due to a rate reduction effective 7/1/16.

The Medi-Cal Expansion category contributed $20,644,000 in revenue, which is $1,890,000 below budget.

Additional membership highlights for September versus budget expectations are noted below. We anticipated that more Healthy Kids members would have transitioned to Medi-Cal by this point in time.

- 2,275 **fewer** member months overall:
  - 548 **more** Medi-Cal Expansion member months
  - 2,227 **fewer** Medi-Cal non-SPD member months

- 585 **fewer** Aged and Disabled (SPD's) member months
- 231 **fewer** Healthy Workers member months
- 220 **more** Healthy Kids member months

MEMBER MONTHS											
	-------SEP 2016------		-VS BUDGET-		----------VS LAST MO----------			----------VS LAST YR----------			
LOB	ACTUAL	BUDGET	FAV (UNFAV)	%	Aug-16	FAV (UNFAV)	%	Sep-15	FAV (UNFAV)	%	Sep-14
MC	63,421	65,648	(2,227)	-3.4%	61,963	1,458	2.4%	61,665	1,756	2.8%	60,268
SPD	14,075	14,660	(585)	-4.0%	14,403	(328)	-2.3%	14,251	(176)	-1.2%	14,339
MCE	57,808	57,260	548	1.0%	57,330	478	0.8%	52,254	5,554	10.6%	35,577
HW	11,264	11,495	(231)	-2.0%	11,287	(23)	-0.2%	11,725	(461)	-3.9%	12,319
HK	900	680	220	32.4%	1,131	(231)	-20.4%	2,005	(1,105)	-55.1%	2,268
TOTAL	147,468	149,743	(2,275)	-1.5%	146,114	1,354	0.9%	141,900	5,568	3.9%	124,771

FEE-FOR-SERVICE CLAIMS

For the month of September, total medical expense is $5,097,000 below budget. This favorable budget variance for September is due primarily to $4,154,000 less in Pharmacy expenses (primarily Hepatitis C costs).

Hospital and Professional fee-for-service claims paid in September totaled $3,128,000. No adjustment to the Incurred But Not Reported (IBNR) claims reserve was needed.

MONTH	FFS CLAIMS PAID	MEMBER MONTHS	PMPM
Sep-16	$ 3,128,000	147,468	$ 21.21
Aug-16	$ 3,919,000	146,114	$ 26.82
Jul-16	$ 3,386,000	146,086	$ 23.18
Jun-16	$ 3,506,000	146,289	$ 23.97
May-16	$ 2,982,000	145,490	$ 20.50
Apr-16	$ 3,735,000	147,668	$ 25.29
Mar-16	$ 4,070,000	144,273	$ 28.21
Feb-16	$ 2,880,000	146,045	$ 19.72
Jan-16	$ 2,998,000	145,014	$ 20.67
Dec-15	$ 3,101,000	147,188	$ 21.07
Nov-15	$ 2,411,000	145,673	$ 16.55
Oct-15	$ 2,632,000	143,524	$ 18.34
Sep-15	$ 3,019,000	141,900	$ 21.28

PHARMACY

For September, total pharmacy costs came in $4,154,000 below budget due to a sharp decline in the number of Hepatitis C treatment weeks. Treatment weeks for Hepatitis C decreased from 483 weeks in August to 456 weeks in September, although still way short of budget projections of 1,106 weeks. Treatment weeks qualifying for reimbursement increased from 419 weeks in August to 424 weeks in September, again way short of budget projections. Our Pharmacy group is contacting lead physicians to understand why treatment weeks continue to come in well below expectations. Pharmacy still believes we will climb to 900-1,100 treatment weeks as the fiscal year moves along.

Total pharmacy expense for September before considering the impact of rebates was $8,263,000 which included $2,889,000 in Hep C costs. The recent trending for non-Hep C drug costs on a per member, per month basis is shown below:

LOB	Sep-16	Aug-16	Jul-16	Jun-16	May-16	Apr-16	Mar-16	Feb-16	Jan-16
MC NON-SPD									
TOTAL RX EXCL REBATES	$1,112,874	$1,090,228	$ 932,099	$1,171,104	$1,201,326	$ 1,168,561	$ 1,217,485	$1,089,634	$ 1,109,150
HEP C	$ 74,910	$ 84,051	$ 106,021	$ 256,382	$ 302,461	$ 275,300	$ 263,025	$ 177,104	$ 245,490
NON-HEP C	$1,037,964	$1,006,177	$ 826,078	$ 914,722	$ 898,865	$ 893,261	$ 954,460	$ 912,530	$ 863,660
MEMBER MONTHS	63,421	61,963	61,195	62,021	61,776	62,284	61,724	63,570	62,248
NON HEP C COST PMPM	**$ 16.37**	**$ 16.24**	**$ 13.50**	**$ 14.75**	**$ 14.55**	**$ 14.34**	**$ 15.46**	**$ 14.35**	**$ 13.87**
MC SPD									
TOTAL RX EXCL REBATES	$3,465,828	$3,583,774	$3,694,587	$4,195,490	$4,311,531	$ 4,169,673	$ 4,166,916	$3,123,932	$ 3,015,446
HEP C	$1,528,476	$1,705,385	$1,823,586	$2,144,050	$2,472,087	$ 2,386,654	$ 2,124,597	$1,415,934	$ 1,309,147
NON-HEP C	$1,937,352	$1,878,389	$1,871,001	$2,051,440	$1,839,444	$ 1,783,019	$ 2,042,319	$1,707,998	$ 1,706,299
MEMBER MONTHS	14,075	14,403	14,623	14,480	14,489	14,916	14,704	14,614	15,181
NON HEP C COST PMPM	**$ 137.64**	**$ 130.42**	**$ 127.95**	**$ 141.67**	**$ 126.95**	**$ 119.54**	**$ 138.90**	**$ 116.87**	**$ 112.40**
MC MCE									
TOTAL RX EXCL REBATES	$3,684,737	$4,016,065	$3,642,551	$4,732,774	$4,449,884	$ 4,016,087	$ 3,591,147	$3,014,416	$ 2,776,758
HEP C	$1,285,558	$1,386,457	$1,379,524	$2,280,607	$2,107,848	$ 1,724,467	$ 1,129,185	$ 803,928	$ 753,076
NON-HEP C	$2,399,179	$2,629,608	$2,263,027	$2,452,167	$2,342,036	$ 2,291,620	$ 2,461,962	$2,210,488	$ 2,023,682
MEMBER MONTHS	57,808	57,330	56,944	56,386	55,753	56,976	54,430	54,391	54,036
NON HEP C COST PMPM	**$ 41.50**	**$ 45.87**	**$ 39.74**	**$ 43.49**	**$ 42.01**	**$ 40.22**	**$ 45.23**	**$ 40.64**	**$ 37.45**

Projected costs for Hepatitis C treatment programs were carved out of the Medi-Cal premium rates paid to SFHP effective July 1, 2014. The State established a kick payment methodology to reimburse managed care plans for Hepatitis C costs. In the month of September, total Hepatitis C costs exceeded reimbursements by $293,000 (DHCS does not reimburse for Daklinza), however when factoring in rebates of $399,000 we had a net surplus of $106,000 on Hep C drugs (95.9% MLR).

	----------HEPATITIS C ACTIVITY----------								
	Sep-16	**Aug-16**	**Jul-16**	**Jun-16**	**May-16**	**Apr-16**	**Mar-16**	**Feb-16**	**Jan-16**
HEP-C REV	$2,595,410	$2,564,804	$2,436,258	$4,545,150	$4,792,777	$4,137,764	$3,243,113	$2,196,689	$2,132,786
HEP-C EXP	$2,489,926	$2,756,641	$2,804,916	$4,073,008	$4,532,215	$3,916,102	$3,055,150	$1,966,621	$1,846,056
GAIN (LOSS)	$ 105,484	$ (191,837)	$ (368,658)	$ 472,142	$ 260,562	$ 221,662	$ 187,963	$ 230,068	$ 286,730

Overall Medi-Cal pharmacy pmpm costs are shown in the table below:

CATEGORY	Sep-16	Aug-16	Jul-16	Jun-16	May-16	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15	Nov-15	Oct-15	12 MONTH AVERAGE
MC - NON-SPD	$ 16.86	$ 16.91	$ 14.52	$ 18.02	$ 15.42	$ 16.08	$ 19.72	$ 15.30	$ 17.82	$ 15.98	$ 14.40	$ 15.02	$ 16.34
MC SPD	$ 230.49	$ 232.97	$ 232.76	$ 267.12	$ 203.19	$ 180.79	$ 273.59	$ 187.79	$ 198.63	$ 248.12	$ 230.15	$ 246.27	$ 227.66
MCE	$ 60.31	$ 66.28	$ 59.74	$ 78.18	$ 59.43	$ 52.97	$ 65.98	$ 49.89	$ 51.39	$ 60.43	$ 61.00	$ 57.95	$ 60.30

MEDICAL LOSS RATIO (MLR)

The medical loss ratios for each line of business for the month of September 2016 are shown below.

- On a year-to-date basis, the MLRs for SPD and MCE are running higher than expected. DHCS eliminated the AIDS category effective 7/1/16, however by contract, SFHP must continue to pay AIDS capitation to Providers until the next round of capitation rate adjustments. The AIDS capitation related to the SPD and MCE populations was $1,044,000 for September.
- The 23.4% reduction in the Hepatitis C kick payment from DHCS is causing the MLR's to be higher than expected.
- HK MLR is lower than what we experienced during FY15-16 due to a 5% premium rate increase effective 7/1/16.

MEDICAL LOSS RATIO					
	-------SEP 2016-------			---------YEAR TO DATE---------	
LINE OF BUSINESS	ACTUAL	BUDGET		ACTUAL	BUDGET
MEDI-CAL NON-SPD	84.9%	85.0%		83.5%	84.9%
MEDI-CAL SPD	96.5%	93.9%		95.5%	93.8%
MEDI-CAL MCE	90.2%	89.8%		95.3%	89.7%
HEALTHY WORKERS	97.6%	98.0%		97.5%	97.9%
HEALTHY KIDS	81.8%	80.8%		82.4%	80.6%
ALL LOB	91.3%	90.7%		93.0%	90.6%

Per member, per month costs are shown in the table below. The unfavorable revenue pmpm for Medi-Cal SPD and Medi-Cal MCE is driven by lower than expected Hepatitis C kick payments.

REVENUE AND MEDICAL EXPENSES - PMPM							
	----------SEP 2016----------				----------YEAR TO DATE----------		
LINE OF BUSINESS	ACTUAL	BUDGET	FAV (UNFAV)		ACTUAL	BUDGET	FAV (UNFAV)
REVENUE							
MEDI-CAL NON-SPD	$ 152.89	$ 160.07	$ (7.18)		$ 156.69	$ 160.10	$ (3.41)
MEDI-CAL SPD	$ 819.73	$ 1,006.11	$ (186.38)		$ 816.11	$ 1,006.48	$ (190.37)
MEDI-CAL MCE	$ 357.12	$ 393.54	$ (36.42)		$ 356.64	$ 393.94	$ (37.30)
HEALTHY WORKERS	$ 375.52	$ 373.82	$ 1.70		$ 375.50	$ 373.82	$ 1.68
HEALTHY KIDS	$ 125.72	$ 125.72	$ -		$ 125.72	$ 125.72	$ -
ALL LOB	$ 313.43	$ 348.43	$ (35.00)		$ 316.18	$ 348.39	$ (32.21)
MEDICAL EXPENSES							
PROFESSIONAL	$ 92.05	$ 93.76	$ 1.71		$ 99.65	$ 93.68	$ (5.97)
HOSPITAL	$ 129.44	$ 120.92	$ (8.52)		$ 130.40	$ 120.87	$ (9.53)
PHARMACY	$ 52.91	$ 79.85	$ 26.94		$ 53.89	$ 79.78	$ 25.89
IMMUNIZATIONS	$ 0.16	$ 0.27	$ 0.11		$ 0.25	$ 0.27	$ 0.02
DENTAL	$ 0.14	$ 0.10	$ (0.04)		$ 0.21	$ 0.12	$ (0.09)
VISION/MENTAL HEALTH	$ 2.56	$ 1.95	$ (0.61)		$ 2.16	$ 1.96	$ (0.20)
HEALTH ED/STOP LOSS	$ 8.97	$ 19.06	$ 10.09		$ 7.55	$ 18.82	$ 11.27
TOTAL	$ 286.23	$ 315.91	$ 29.68		$ 294.11	$ 315.50	$ 21.39

ADMINISTRATIVE EXPENSE

Administrative expenses ended the month $690,000 below budget. The majority of the underspending is found in the areas of Professional Fees/Consulting and Other Expenses which includes member materials, software maintenance/licensing/support, computer hardware, telecommunications, etc.

The month of September followed the typical pattern for administrative expenses in the first quarter of the fiscal year, i.e., the carryover of expenses from June was virtually eliminated and expenses tend to be budgeted a little heavier in the early months of the fiscal year.

Total CalPERS pension costs continue to decline due to an increasing percentage of employees covered by the new pension rules which became effective January 1, 2013. Currently 35% of our staff is in the Classic category (8.377% employer contribution) and 65% is in the California Public Employees' Pension Reform Act (PEPRA) category (6.555% employer contribution).

Professional Fees and Consulting expenses are $534,000 below budget for the month. Several large projects such as QNXT reconfiguration, systems security assessment and the new member/provider portal have not yet fully launched. Costs related to these projects and others tied to SFHP organizational goals for FY16-17 are expected to ramp up during the second quarter.

Pharmacy and non-specialty mental health TPA services continue to be classified as administrative expense. These TPA services totaled $312,000 for September.

	----------SEP 2016----------			----------YEAR TO DATE----------		
ADMINISTRATIVE EXPENSES	**ACTUAL**	**BUDGET**	**FAV (UNFAV)**	**ACTUAL**	**BUDGET**	**FAV (UNFAV)**
COMPENSATION/BENEFITS	$ 2,018,800	$ 2,100,540	$ 81,740	$ 5,700,761	$ 6,003,609	$ 302,848
GASB 68	$ (11,121)	$ (64,983)	$ (53,862)	$ (29,540)	$ (182,786)	$ (153,246)
LEASE/INSURANCE/DEPN/AMORT	$ 493,709	$ 520,916	$ 27,207	$ 1,482,432	$ 1,556,201	$ 73,769
MARKETING AND OUTREACH	$ 40,151	$ 66,376	$ 26,225	$ 194,190	$ 196,529	$ 2,339
TPA FEES - PBM AND MENTAL HEALTH	$ 311,758	$ 287,409	$ (24,349)	$ 904,941	$ 880,953	$ (23,988)
PROFESSIONAL FEES/CONSULTING	$ 225,374	$ 759,657	$ 534,283	$ 943,324	$ 2,231,070	$ 1,287,746
OTHER EXPENSES	$ 552,514	$ 651,146	$ 98,632	$ 1,554,461	$ 1,999,531	$ 445,070
TOTAL	$ 3,631,185	$ 4,321,061	$ 689,876	$ 10,750,569	$ 12,685,107	$ 1,934,538
ADMINISTRATIVE EXPENSE RATIO	6.4%	6.8%		6.2%	6.6%	

San Francisco Health Plan
Finance Big Picture Dashboard - September 2016

	Sep-16			Sep-15	Fiscal Year to Date (16/17)			FY 15/16
	MTD	MTD	MTD	MTD	FYTD	FYTD	FYTD	FYTD
	Actual	Budget	Fav (Unfav)	Actual	Actual	Budget	Fav (Unfav)	Actual
FINANCIAL POSITION:								
Net Profit/Loss w/o HSF ($)	1,107,871	1,380,066	(272,195)	3,044,152	1,150,736	4,533,665	(3,382,929)	10,322,825
Total Medical Loss Ratio_All LOB	91.3%	90.7%	-0.7%	87.2%	93.0%	90.6%	-2.5%	87.9%
Admin Expense Ratio	6.4%	6.8%	0.4%	6.4%	6.2%	6.6%	0.4%	4.6%
Number of FTE's	306			283				
Premium Revenue ($)	46,221,391	52,174,856	(5,953,465)	46,458,938	139,014,495	156,021,039	(17,006,544)	136,462,699
Medical Expenses ($)	42,208,432	47,305,753	5,097,321	40,512,099	129,308,620	141,291,444	11,982,824	119,991,485
Administration Expenses w/o HSF ($)	3,631,186	4,321,061	689,875	3,980,609	10,750,568	12,685,107	1,934,539	9,062,638
Member Months	147,468	149,743	(2,275)	141,900	439,668	447,840	(8,172)	420,995
Cash on Hand (Days)	62			47				

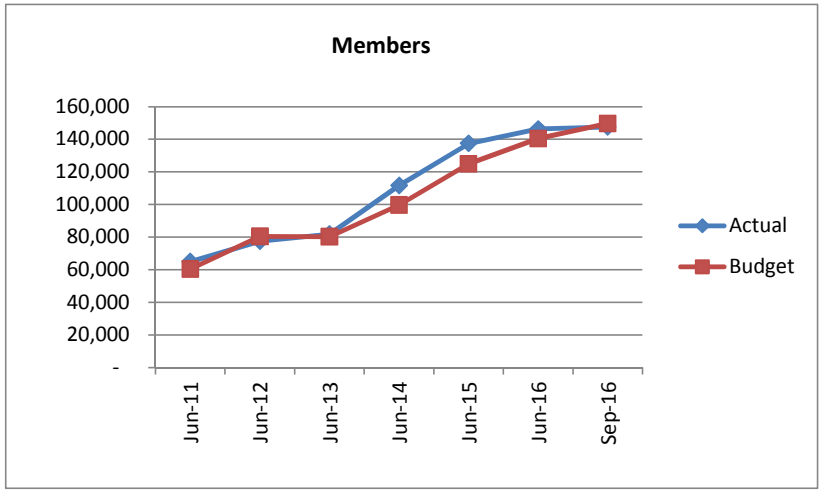
RESERVES:	Current Month	FY15-16 Budget	June 2015	June 2014	June 2013	June 2012	June 2011	June 2010
Reserves ($)	112,129,305	103,143,192	82,714,329	47,449,830	36,222,858	25,692,434	30,145,085	30,556,325
DMHC Required TNE	11,566,125	9,185,295	8,673,851	6,969,756	4,070,440	3,511,350	2,641,288	2,588,435
Reserves as a Multiple of TNE	9.7	11.2	10.1	6.8	8.9	7.3	11.4	11.8
Board Approved Reserve (2x Premium Rev)	92,442,782	91,601,264	51,400,000	30,084,000	27,050,000	27,050,000	27,050,000	27,050,000
Reserves in Excess of Board Approved	19,686,523	11,541,928						

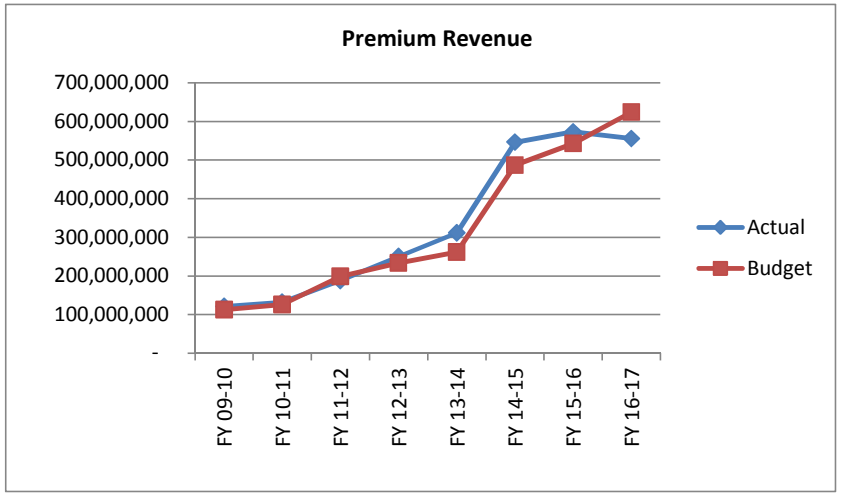
FINANCIAL TREND:	**Fiscal 2016 Original Budget**	**Change**
Premium Revenue ($)	156,021,039	(17,006,544)
Medical Expenses ($)	141,291,444	11,982,824
Administration Expenses w/o HSF ($)	12,685,107	1,934,539

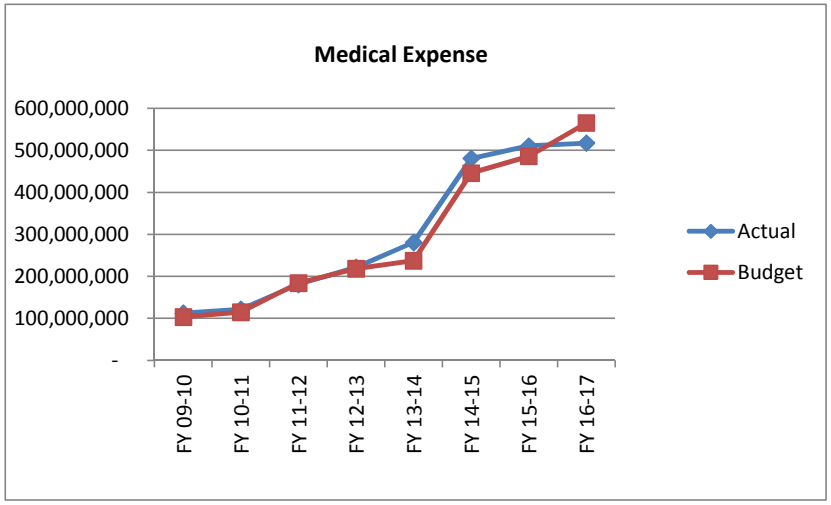
	Current Month	June-2016	June-2015	June-2014	June-2013	June-2012	June-2011	
Member Months	147,468	146,289	137,427	111,590	81,785	77,531	64,968	Membership for the Month
Average Monthly Enrollment	145,903	144,347	130,240	91,587	79,422	72,502	61,993	Rolling 12 Month Average

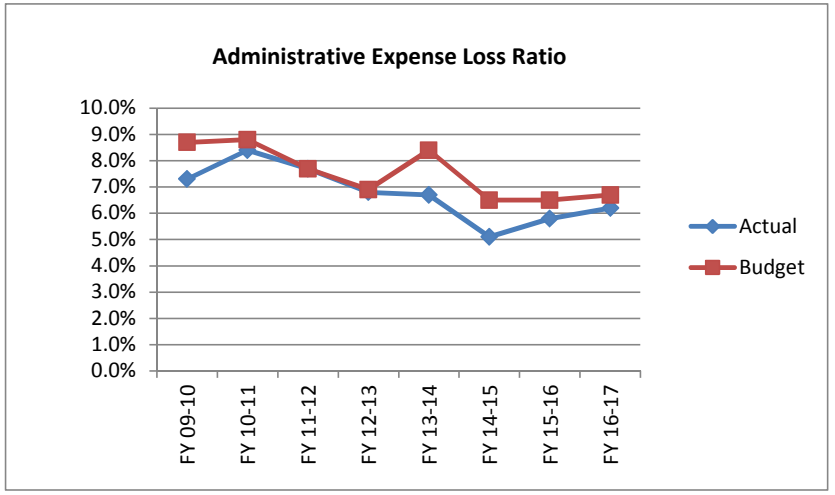
San Francisco Health Plan
Finance Big Picture Dashboard - September 2016

FINANCIAL TREND:
(Rolling 12 months)









San Francisco Health Plan

Finance Dashboard Metrics - September 2016

	Sep-16			Sep-15	Fiscal Year to Date (16/17)			FY 15/16
	Actual	Budget	Fav (Unfav)	Actual	Actual	Budget	Fav (Unfav)	Actual
Member Months	147,468	149,743	(2,275)	141,900	439,668	447,840	(8,172)	420,995
			-1.5%				-1.8%	
Premium Revenue ($)	46,221,391	52,174,856	(5,953,465)	46,458,938	139,014,495	156,021,039	(17,006,544)	136,462,699
			-11.4%				-10.9%	
Administration Expenses w/o HSF ($)	3,631,186	4,321,061	689,875	3,980,609	10,750,568	12,685,107	1,934,539	9,062,638
Admin Expense Ratio	6.4%	6.8%		6.4%	6.2%	6.6%		4.6%
Medical Expenses ($)	42,208,432	47,305,753	5,097,321	40,512,099	129,308,620	141,291,444	11,982,824	119,991,485
Total Medical Loss Ratio	91.3%	90.7%		87.2%	93.0%	90.6%		87.9%
MC Medical Loss Ratio	84.9%	85.0%		72.9%	83.5%	84.9%		75.3%
MC SPD Medical Loss Ratio	96.5%	93.9%		90.1%	95.5%	93.8%		89.5%
MC Expansion	90.2%	89.8%		90.6%	95.3%	89.7%		91.5%
HW Medical Loss Ratio	97.6%	98.0%		97.8%	97.5%	97.9%		98.0%
HK Medical Loss Ratio	81.8%	80.8%		82.9%	82.4%	80.6%		86.3%
HSF + SFCMRA - TPA Fee ($)	701,356	801,852	(100,496)	654,185	1,888,682	2,405,555	(516,873)	1,564,673
			-12.5%				-21.5%	
Cash on Hand (Days)	62			47				
Maternity Reimb. Performance ($)	706,441	755,084	(48,643)	739,354	2,563,223	2,265,252	297,971	2,265,254
(per case pymt, actual vs. budget)			-6.4%				13.2%	
Number of Births	81	96	(15)	94	295	288	7	288
Hep-C Revenue ($)	2,595,410	7,221,116		2,763,835	7,596,472	21,663,347.52		6,619,015
Hep-C Expense w/rebates (FFS + Cap) ($)	2,489,926	6,229,380		2,728,691	8,051,482	18,688,140		6,454,978
Net Margin ($)	105,484	991,736		35,144	(455,010)	2,975,208		164,037
Total Hep-C Treatments	456	1,106		360	1,415	3,318		844
Total reimbursable Hep-C weeks (exclude Daklinza)	424	904		346	1,241	2,712		828
Net Profit/Loss w/o HSF ($)	1,107,871	1,380,066	(272,195)	3,044,152	1,150,736	4,533,665	(3,382,929)	10,322,825

San Francisco Health Plan

Consolidated Balance Sheet for SFHA and SFCHA

As of September 30, 2016

	SFHA	HSF	9/30/2016 Total	9/30/2015 Total	Variance
			ASSETS		
	CURRENT ASSETS				
(1)	SFHP Cash and Cash Equivalents	206,743,981		206,743,981	115,483,187	91,260,794
	HSF Cash and Cash Equivalents		196,262,670	196,262,670	144,107,861	52,154,809
	Short Term Investments	3,022,883		3,022,883	5,238,786	(2,215,903)
	Petty Cash	1,000		1,000	1,000	-
	Other Receivables	4,769,066		4,769,066	3,889	4,765,177
	Interest Receivable	125,901		125,901	179,746	(53,846)
	Grant Funds Receivable	620,212		620,212	830,471	(210,259)
(2)	Capitation Receivable	71,412,966		71,412,966	63,121,337	8,291,629
	HSF Operation Receivable	2,168,868		2,168,868	1,564,666	604,202
	HSF Provider Payment & Advance		297,183	297,183	415,078	(117,895)
	HSF Receivables		570,305	570,305	520,245	50,060
	Prepaid Insurance	66,226		66,226	73,211	(6,985)
	HSF Prepaid Insurance	7,395		7,395	6,723	672
	Prepaid Rent	301,684		301,684	35,975	265,709
	Prepaid Expenses	2,113,010		2,113,010	1,421,480	691,530
	HSF Prepaid Expenses	16,425		16,425	29,550	(13,125)
	CalPERS Deferred Outflow Fund	3,374,335		3,374,335	3,560,598	(186,263)
	Deposits	119,874		119,874	341,948	(222,074)
	Total Current Assets	294,863,825	197,130,158	491,993,983	336,935,751	155,058,232
	OTHER ASSETS					
	Long Term Investments	19,839,162		19,839,162	17,230,596	2,608,566
	Restricted Funds Required by DMHC	300,000		300,000	300,000	-
	Total Other Assets	20,139,162	-	20,139,162	17,530,596	2,608,566
	FIXED ASSETS					
	Furniture & Equipment	13,547,471		13,547,471	13,023,160	524,311
	Accumulated Depreciation	(4,909,428)		(4,909,428)	(2,922,847)	(1,986,581)
	Net Fixed Assets	8,638,043	-	8,638,043	10,100,313	(1,462,270)
	TOTAL ASSETS	**323,641,029**	**197,130,158**	**520,771,187**	**364,566,660**	**156,204,527**

San Francisco Health Plan

Consolidated Balance Sheet for SFHA and SFCHA

As of September 30, 2016

	SFHA	HSF	9/30/2016 Total	9/30/2015 Total	Variance
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES				
	Accounts Payable	6,724,798		6,724,798	3,222,733	3,502,065
	HSF Accounts Payable		373,864	373,864	115,973	257,891
	Deferred Rent	1,619,036		1,619,036	10,357	1,608,679
	Salaries/Benefits/PERS Payable	4,394,489		4,394,489	4,699,435	(304,946)
	CalPERS Unfunded Pension	162,595		162,595	3,015,009	(2,852,414)
	CalPERS Pension Deferred Inflow	5,648,256		5,648,256	1,558,640	4,089,616
	Notes Payable - Lease Equipment	252,002		252,002	320,220	(68,218)
	Unearned Premium Revenue	1,774,888		1,774,888	1,774,888	-
(3)	DHCS and Pass-Through Payables	111,984,361		111,984,361	46,554,743	65,429,618
	MCE MLR Payable to U.S. Treasury	7,376,087		7,376,087	7,376,087	-
	HSF Earned Premium - Due to DPH		476,302	476,302	437,779	38,523
	HSF Unearned Participant Fees		1,829,217	1,829,217	1,748,191	81,026
	ESR due to DPH		3,392,785	3,392,785	4,253,301	(860,516)
	HSF MRA Fund Payable (Claim & Fee)		191,057,990	191,057,990	138,487,941	52,570,049
	Capitation Payable	62,868,246		62,868,246	49,847,582	13,020,664
	Claims Payable	2,764,907		2,764,907	2,725,033	39,874
	Claims IBNR	4,636,904		4,636,904	4,004,833	632,071
	Pharmacy Reserves	793,638		793,638	794,136	(498)
	Various Pools / Reserves	511,516		511,516	560,623	(49,107)
	TOTAL LIABILITIES	211,511,724	197,130,158	408,641,882	271,507,504	137,134,378
	FUND BALANCE					
	Contributed Capital	1,516,840		1,516,840	1,516,840	-
	Accumulated Surplus Revenue	109,447,847		109,447,847	81,197,489	28,250,358
	Current Year Surplus / Deficit	1,164,618		1,164,618	10,344,827	(9,180,209)
	Fund Balance	112,129,305	-	112,129,305	93,059,156	19,070,149
	TOTAL LIABILITIES & FUND BALANCE	**323,641,029**	**197,130,158**	**520,771,187**	**364,566,660**	**156,204,527**
		-	-	-	-	-

San Francisco Health Plan

Consolidated Balance Sheet for SFHA and SFCHA

As of September 30, 2016

Notes:

(1) (2) & (3) As of September 30 our combined Cash and Capitation Receivable balance was $278.2 million. As of July 31 the combined balance was $261.2 million. These balances remain within our expected range and provide adequate cash flows. The increase from July to September is primarily due to DHCS continuing to pay us old rates while new rates are in affect. DHCS will continue to pay us the old rates until there is final approval from CMS to move ahead with new rates. We accrue the future pay back in the account titled DHCS and Provider Pass-Throughs which currently consists of MCO taxes payable of $1.2 million, AB85 payable of $6.9 million, and an MCE rate difference payable to DHCS of $104.0 million. As of September 30 our days cash on hand are 62 days. The days cash on hand exclude cash reserved for the above noted pay backs. Receivable balances at July 31 consist primarily of one month of premium payments from DHCS and twelve months of AIDS premiums.

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
As of September 30, 2016

	Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
					Member Month				
(1)	63,421	65,648	(2,227)	(3.4%)	Medi-Cal	186,579	196,672	(10,093)	(5.1%)
	14,075	14,660	(585)	(4.0%)	Medi-Cal SPD	43,101	43,922	(821)	(1.9%)
	57,808	57,260	548	1.0%	Medi-Cal Expansion	172,082	170,400	1,682	1.0%
	11,264	11,495	(231)	(2.0%)	Healthy Workers	33,896	34,539	(643)	(1.9%)
	900	680	220	32.4%	Healthy Kids	4,010	2,307	1,703	73.8%
	147,468	149,743	(2,275)	(1.5%)	TOTAL MEMBER MONTH	439,668	447,840	(8,172)	(1.8%)
					REVENUE				
(2)	9,696,237	10,508,544	(812,307)	(7.7%)	Medi-Cal	29,235,689	31,486,289	(2,250,600)	(7.1%)
	11,537,637	14,749,520	(3,211,883)	(21.8%)	Medi-Cal SPD	35,175,164	44,206,767	(9,031,603)	(20.4%)
	20,644,495	22,534,298	(1,889,803)	(8.4%)	Medi-Cal Expansion	61,371,649	67,126,749	(5,755,101)	(8.6%)
	4,229,873	4,297,004	(67,130)	(1.6%)	Healthy Workers	12,727,857	12,911,198	(183,341)	(1.4%)
	113,148	85,490	27,658	32.4%	Healthy Kids	504,137	290,036	214,101	73.8%
	46,221,391	52,174,856	(5,953,465)	(11.4%)	Total Capitation Revenue	139,014,495	156,021,039	(17,006,543)	(10.9%)
	654,685	655,292	(607)	(0.1%)	Other Income - Admin Svc & TPL	2,005,657	1,965,876	39,781	2.0%
	22,912	118,731	(95,819)	(80.7%)	Healthy Kids Grant	111,716	349,302	(237,586)	(68.0%)
	677,597	774,023	(96,426)	(12.5%)	Total Other Income	2,117,372	2,315,177	(197,805)	(8.5%)
	46,898,988	**52,948,879**	**(6,049,892)**	**(11.4%)**	**TOTAL REVENUE**	**141,131,868**	**158,336,216**	**(17,204,348)**	**(10.9%)**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
As of September 30, 2016

	Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
					EXPENSES				
					Medical Expenses				
(3)	13,573,824	14,040,311	466,486	3.3%	Professional	43,813,056	41,954,268	(1,858,788)	(4.4%)
	19,088,684	18,106,696	(981,987)	(5.4%)	Hospital	57,333,740	54,129,070	(3,204,671)	(5.9%)
(4)	7,802,614	11,956,872	4,154,258	34.7%	Pharmacy	23,694,129	35,728,554	12,034,425	33.7%
	23,536	40,272	16,736	41.6%	Immunizations	108,668	120,886	12,218	10.1%
	20,376	15,395	(4,981)	(32.4%)	Dental	90,786	52,230	(38,556)	(73.8%)
	376,841	292,667	(84,174)	(28.8%)	Vision and Mental Health	949,097	878,390	(70,707)	(8.0%)
	1,322,557	2,853,541	1,530,984	53.7%	Health Ed & Stop Loss & Other	3,319,144	8,428,046	5,108,902	60.6%
	42,208,432	**47,305,753**	**5,097,321**	**10.8%**	**Total Medical Expenses**	**129,308,620**	**141,291,444**	**11,982,823**	**8.5%**
	91.3%	90.7%			Medical Cost Ratio %	93.0%	90.6%		
					Operating Expenses				
	2,018,800	2,100,540	81,740	3.9%	Compensation & Benefits	5,700,761	6,003,609	302,848	5.0%
	(11,121)	(64,983)	(53,862)	0.0%	GASB-68 CalPERS Contribution	(29,540)	(182,786)	(153,246)	0.0%
	493,709	520,916	27,207	5.2%	Lease, Insurance, D & A	1,482,432	1,556,201	73,769	4.7%
	40,151	66,376	26,225	39.5%	Marketing & Outreach	194,190	196,529	2,339	1.2%
	311,758	287,409	(24,349)	(8.5%)	PBM and Mental Health TPA Fees	904,941	880,953	(23,988)	(2.7%)
	225,374	759,657	534,283	70.3%	Professional Fees & Consulting	943,324	2,231,070	1,287,746	57.7%
	552,514	651,146	98,631	15.1%	Other Expenses	1,554,461	1,999,531	445,070	22.3%
	3,631,186	4,321,061	689,874	16.0%	Total Operating Expenses	10,750,568	12,685,107	1,934,539	15.3%
	6.4%	6.8%			Administrative Cost Ratio %	6.2%	6.6%		
					(Op Exp-Other Inc/Premium)				
	45,839,618	**51,626,813**	**5,787,195**	**11.2%**	**TOTAL EXPENSES**	**140,059,189**	**153,976,551**	**13,917,362**	**9.0%**
	1,059,370	**1,322,066**	**(262,697)**	**(19.9%)**	**Operating Surplus / Deficit**	**1,072,679**	**4,359,665**	**(3,286,987)**	**(75.4%)**
	51,318	58,000	(6,682)	(11.5%)	Interest Income & Realized G/L on Investment	156,290	174,000	(17,710)	(10.2%)
	(2,817)	0	(2,817)		Unrealized Gain / Loss on Investment	(78,233)	0	(78,233)	
	48,502	58,000	(9,498)	(16.4%)	Total Interest Income & Realized G/L on Investment	78,058	174,000	(95,942)	(55.1%)
	1,107,871	**1,380,066**	**(272,195)**	**(19.7%)**	**SURPLUS / DEFICIT**	**1,150,736**	**4,533,665**	**(3,382,929)**	**(74.6%)**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
As of September 30, 2016

Notes:

(1) Overall membership is below budget by 2,227 primarily due to slower growth in Medi-Cal non-SPD membership than budgeted. We have seen a small increase in membership since last reported at the September board meeting where we were 2,731 members below budget.

(2) Premium revenue for September was $46,221,000 versus a budget of $52,175,000. July revenue was $47,006,000. This decrease is the result of several factors; SFHP experienced a reduction in MCE premium rates effective 7/1/16. For the month of September, compared to budget, we received $4,626,000 less Hepatitis C kick revenue and $14,007,000 less revenue year to date. Our Hepatitis C expenses are also lower, however, our reduction in related margin is approximately $3,000,000. Our Medi-Cal membership is also below budget resulting in a reduction of gross revenue. One a PMPM basis SPD revenue was $186 below budget due to the lower Hepatitis C utilization.

(3) On a year to date total dollar and PMPM basis Professional and Hospital expenses exceed budget. This fiscal year our expenses have been trending higher as we continue to pay the aids supplemental rates to providers even though DHCS blended the aids payments into our category of aid rates effective July 1. The amount aids dollars blended into the rate is less than what we were previously paid and as a result, we are working with DHCS to adjust the rate. We have also see an increasing trend in our fee for service medical cost over the last quarter. Fee-for-service claims paid in September equaled $3,128,000, in August $3,919,000, and in July totaled $3,386,000 as compared to an average amount for the previous ten months of $3,133,000.

(4) For September, total pharmacy costs were $4,154,000 below budget which is consistence with the previous months of this fiscal year. This is due to lower than anticipated utilization when compared to budget and a sharp decline in the number of actual Hepatitis C treatment weeks. Treatment weeks for Hepatitis C 424 weeks compared to an expected amount of 904 as budgeted. Treatment weeks qualifying for reimbursement decreased from 569 weeks in June to 398 weeks in July.

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
As of September 30, 2016
($ PMPM)

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %
				REVENUE				
152.89	160.07	(7.19)	(4.5%)	Medi-Cal	156.69	160.10	(3.40)	(2.1%)
819.73	1,006.11	(186.38)	(18.5%)	Medi-Cal SPD	816.11	1,006.48	(190.37)	(18.9%)
357.12	393.54	(36.42)	(9.3%)	Medi-Cal Expansion	356.64	393.94	(37.29)	(9.5%)
375.52	373.82	1.71	0.5%	Healthy Workers	375.50	373.82	1.68	0.5%
125.72	125.72	0.00	0.0%	Healthy Kids	125.72	125.72	0.00	0.0%
313.43	**348.43**	**(35.00)**	**(10.0%)**	**Total Capitation Revenue**	**316.18**	**348.39**	**(32.21)**	**(9.2%)**
4.44	4.38	0.06	1.4%	Other Income - Admin Svc & TPL	4.56	4.39	0.17	3.9%
0.16	0.79	(0.64)	(80.4%)	Healthy Kids Grant	0.25	0.78	(0.53)	(67.4%)
4.59	**5.17**	**(0.57)**	**(11.1%)**	**Total Other Income**	**4.82**	**5.17**	**(0.35)**	**(6.8%)**
318.03	**353.60**	**(35.57)**	**(10.1%)**	**TOTAL REVENUE**	**321.00**	**353.56**	**(32.56)**	**(9.2%)**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
As of September 30, 2016
($ PMPM)

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %
				EXPENSES				
				Medical Expenses				
92.05	93.76	1.72	1.8%	Professional	99.65	93.68	(5.97)	(6.4%)
129.44	120.92	(8.52)	(7.0%)	Hospital	130.40	120.87	(9.54)	(7.9%)
52.91	79.85	26.94	33.7%	Pharmacy	53.89	79.78	25.89	32.5%
0.16	0.27	0.11	40.7%	Immunizations	0.25	0.27	0.02	8.4%
0.14	0.10	(0.04)	(34.4%)	Dental	0.21	0.12	(0.09)	(77.0%)
2.56	1.95	(0.60)	(30.7%)	Vision and Mental Health	2.16	1.96	(0.20)	(10.1%)
8.97	19.06	10.09	52.9%	Health Ed & Stop Loss & Other	7.55	18.82	11.27	59.9%
286.22	**315.91**	**29.69**	**9.4%**	**Total Medical Expenses**	**294.11**	**315.50**	**21.39**	**6.8%**
91.3%	90.7%			Medical Cost Ratio %	93.0%	90.6%		
				Operating Expenses				
13.69	14.03	0.34	2.4%	Compensation & Benefits	12.97	13.41	0.44	3.3%
(0.08)	(0.43)	(0.36)	0.0%	GASB-68 CalPERS Contribution	(0.07)	(0.41)	(0.34)	0.0%
3.35	3.48	0.13	3.8%	Lease, Depreciation & Amortization	3.37	3.47	0.10	3.0%
0.27	0.44	0.17	38.6%	Marketing & Outreach	0.44	0.44	(0.00)	(0.6%)
2.11	1.92	(0.19)	(10.1%)	PBM and Mental Health TPA Fees	2.06	1.97	(0.09)	(4.6%)
1.53	5.07	3.54	69.9%	Professional Fees & Consulting	2.15	4.98	2.84	56.9%
3.75	4.35	0.60	13.8%	Other Expenses	3.54	4.46	0.93	20.8%
24.62	**28.86**	**4.23**	**14.7%**	**Total Operating Expenses**	**24.45**	**28.33**	**3.87**	**13.7%**
6.4%	6.8%			Administrative Cost Ratio %	6.2%	6.6%		
310.84	**344.77**	**33.92**	**9.8%**	**TOTAL EXPENSES**	**318.56**	**343.82**	**25.26**	**7.3%**
7.18	**8.83**	**(1.65)**	**-18.6%**	**Operating Surplus / Deficit**	**2.44**	**9.73**	**(7.30)**	**-74.9%**
0.35	0.39	(0.04)	(10.2%)	Interest Income & Realized G/(L) on Investment	0.36	0.39	(0.03)	(8.5%)
(0.02)	0.00	(0.02)	-	Unrealized Gain / (Loss) on Investment	(0.18)	0.00	(0.18)	-
0.33	0.39				0.18	0.39		
7.51	**9.22**	**(1.70)**	**-18.5%**	**SURPLUS / DEFICIT**	**2.62**	**10.12**	**(7.51)**	**-74.1%**

San Francisco Health Plan
Income Statement
Healthy San Francisco & SF Covered MRA
As of September 30, 2016

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
				REVENUE				
701,356	**801,852**	**(100,495)**	**-12.5%**	**TPA Fee - HSF + SFCMRA**	**1,888,682**	**2,405,555**	**(516,873)**	**(21.5%)**
				EXPENSES				
392,361	465,564	73,204	15.7%	Compensation & Benefits	1,148,628	1,367,151	218,523	16.0%
44,315	93,171	48,856	52.4%	Lease, Insurance, D & A	132,945	279,513	146,569	52.4%
117,150	81,928	(35,222)	(43.0%)	Marketing & Outreach	254,273	245,783	(8,490)	(3.5%)
127,406	117,567	(9,840)	(8.4%)	Professional Fees & Consulting	304,404	352,700	48,296	13.7%
7,881	53,106	45,225	85.2%	Other Expenses	34,550	159,319	124,769	78.3%
689,113	**811,336**	**122,223**	**15.1%**	**TOTAL EXPENSES**	**1,874,801**	**2,404,467**	**529,666**	**22.0%**
98.3%	101.2%			Administrative Cost Ratio %	99.3%	100.0%		
12,243	**(9,484)**	**21,728**	**-229.1%**	**SURPLUS / DEFICIT**	**13,882**	**1,088**	**12,793**	**1175.4%**

Make up of Net Loss:		
Net Loss		13,882
Items for which cash was paid in a prior period, and billed to HSF (currently being amortized):		
Depreciation expense net of capital assets		0
Postage Deposit @ Fulfillment House		0
Insurance Expense (Net of billable amount)		4,437
License Fees (Net of billable items for IT products)		(18,319)
Deferred Rent		
		(13,882)
Net difference		(0)

San Francisco Health Plan

Investment Performance

(excludes balances in SFHA operating accounts)

September 30, 2016

Fixed Income Securities	Purchase Date	Quantity	Purchase Price	9/30/16 Price	Market Value 9/30/16	Amortized Prem / Disc	Unrealized Gain (Loss)	Estimated Annual Income
Local Agency Investment Fund (LAIF) - rate @ 0.634%			$ 1,726,744		$ 1,726,744	$ -	$ -	$ 10,948
Principle Cash								
CNB Charter Prime Money Market Fund - 0.030%		77,440	$ 77,440	$ 1.00	$ 77,440	$ -	$ -	$ 23
Total Cash and Cash Equivalents					**$ 77,440**			
Fixed Income								
U. S. Treasury N/B - 0.875% Mat - 4/30/17	2/15/13	1,070,000	$ 1,077,569	$ 100.20	$ 1,072,108	$ (6,520)	$ 1,059	$ 9,363
US Treasury Note - 1.750% - Mat 10/31/18	7/21/15	1,115,000	$ 1,138,358	$ 101.93	$ 1,136,564	$ (10,068)	$ 8,275	$ 19,513
US Treasury Note - 0.875% - Mat 05/31/18	6/30/16	1,140,000	$ 1,144,207	$ 100.21	$ 1,142,360	$ (1,877)	$ 30	$ 9,975
US Treasury Note - 1.5% - Mat 5/31/19	6/30/16	280,000	$ 286,202	$ 101.68	$ 284,693	$ (537)	$ (972)	$ 4,200
US Treasury Note - 1.625% - Mat 6/30/20	6/30/16	1,120,000	$ 1,151,544	$ 102.18	$ 1,144,416	$ (1,992)	$ (5,136)	$ 18,200
US Treasury Note - 1.125% - Mat 6/30/21	6/30/16	1,140,000	$ 1,146,190	$ 99.88	$ 1,138,666	$ (313)	$ (7,211)	$ 12,825
Federal Home Loan Mortgage Corp - 1.000% Mat - 9/29/17	9/14/12	695,000	$ 698,544	$ 100.31	$ 697,168	$ (2,828)	$ 1,453	$ 6,950
Chase Issuance Trust - 1.37% - Mat 06/15/2021	6/17/16	580,000	$ 579,999	$ 100.29	$ 581,699	$ 0	$ 1,701	$ 7,946
Nissan Master Owner Trust Rec - 1.540% - Mat 06/15/2021	7/19/16	505,000	$ 504,928	$ 99.67	$ 503,323	$ 3	$ (1,608)	$ 7,777
Federal National Mortgage Assn - Variable rate 0.552% Mat - 7/20/17	12/4/15	680,000	$ 679,330	$ 100.05	$ 680,326	$ (333)	$ 1,329	$ 3,754
Federal Home Loan Mortgage Corp - 0.750% Mat - 1/12/18	2/15/13	1,090,000	$ 1,077,977	$ 99.97	$ 1,089,684	$ 8,868	$ 2,838	$ 8,175
Federal Home Loan Mortgage Corp - 0.875% Mat - 3/7/18	2/26/14	630,000	$ 620,147	$ 100.08	$ 630,491	$ 6,342	$ 4,002	$ 5,513
Federal Home Loan Mortgage Corp - 1.5% Mat -11/30/20	10/19/15	675,000	$ 674,669	$ 101.35	$ 684,086	$ 62	$ 9,354	$ 10,125
Federal Home Loan Mortgage Corp - 1.625% Mat - 6/14/19	2/13/15	1,120,000	$ 1,132,762	$ 101.58	$ 1,137,718	$ (6,393)	$ 11,349	$ 18,200
Federal Home Loan Mortgage Corp - 1.375% Mat - 5/1/20	2/13/15	675,000	$ 665,692	$ 101.09	$ 682,324	$ 2,891	$ 13,741	$ 9,281
Federal Home Loan Mortgage Assn - 2% - Mat 11/25/30	1/13/16	388,325	$ 389,570	$ 101.23	$ 393,082	$ (60)	$ 3,572	$ 7,766
Federal National Mortgage Assn - 1.875% Mat - 9/18/18	8/29/13	700,000	$ 699,321	$ 102.04	$ 714,280	$ 415	$ 14,544	$ 13,125
Total Fixed Income		**13,603,325**	**$ 13,667,006**		**$ 13,712,989**	**$ (12,337)**	**$ 58,320**	**$ 172,687**
Corporate Bonds - Domestic								
JP Morgan Chase & Co. - 6.00% Mat - 1/15/18	3/18/13	630,000	$ 748,755	$ 105.65	$ 665,608	$ (86,673)	$ 3,526	$ 37,800
Goldman Sachs. - 6.00% Mat - 6/15/20	4/26/16	590,000	$ 669,697	$ 113.74	$ 671,048	$ (8,208)	$ 9,559	$ 35,400
Morgan Stanley. - 5.750%% Mat - 1/25/21	4/26/16	590,000	$ 674,022	$ 113.99	$ 672,565	$ (7,980)	$ 6,523	$ 33,925
CitiGroup, Inc. - Variable rate 2.517% Mat - 5/15/18	5/2/14	645,000	$ 670,290	$ 101.57	$ 655,133	$ (15,060)	$ (97)	$ 16,235
GE Cap Corp. -5.55% Mat 5/4/20	4/20/16	580,000	$ 670,758	$ 113.32	$ 657,268	$ (9,866)	$ (3,625)	$ 32,190
Anheuser-Busch. - Variable rate 2.017% Mat - 02/01/21	1/25/16	675,000	$ 678,240	$ 102.63	$ 692,780	$ (435)	$ 14,975	$ 13,615
Metlife. - 4.750% Mat - 02/08/21	6/24/16	605,000	$ 675,997	$ 111.95	$ 677,273	$ (3,114)	$ 4,391	$ 28,738
Wells Fargo & Company - 2.550% Mat - 12/07/2020	8/4/16	665,000	$ 685,622	$ 101.96	$ 678,047	$ (729)	$ (6,845)	$ 16,958
Simon Property Group - 2.200% Mat - 2/1/19	2/18/15	650,000	$ 659,302	$ 101.93	$ 662,539	$ (3,797)	$ 7,034	$ 14,300
Total Corporate Bonds - Domestic		**5,630,000**	**$ 6,132,683**		**$ 6,032,260**	**$ (135,864)**	**$ 35,440**	**$ 229,159**
Foreign Bonds								
BNP Paribas Corp - 5% Mat 1/15/2021	4/1/16	605,000	$ 676,323	$ 111.89	$ 676,928	$ (7,442)	$ 8,047	$ 30,250
Total Foreign Bonds		**605,000**	**$ 676,323**		**$ 676,928**	**$ (7,442)**	**$ 8,047**	**$ 30,250**
Municipal Bonds								
New York State - 2.790% Mat-03/15/2021	3/22/16	440,000	$ 455,972	$ 103.64	$ 456,007	$ (576)	$ 611	$ 12,276
Florida St Hurricane - 2.107% Mat 7/1/2018	7/6/10	645,000	$ 648,999	$ 101.87	$ 657,074	$ (1,874)	$ 9,949	$ 13,590
Pacifica CA Pension Go Bonds - 5.108% Mat 6/1/2017	7/6/10	485,000	$ 497,964	$ 102.24	$ 495,840	$ (15,823)	$ 13,702	$ 24,774
Total Municipal Bonds		**1,570,000**	**$ 1,602,935**		**$ 1,608,921**	**$ (18,273)**	**$ 24,262**	**$ 50,640**
Municipal Zero Coupon Bonds								
Federal National Mortgage Assn - 0.00% Mat - 10/9/19	6/30/14	785,000	$ 694,170	$ 95.99	$ 753,506	$ 38,065	$ 21,271	$ 17,433
Total Zero Coupon Bonds		**785,000**	**$ 694,170**		**$ 753,506**	**$ 38,065**	**$ 21,271**	**$ 17,433**
Total of City National Investments		**22,193,325**	**$ 22,773,118**		**$ 22,784,604**	**$ (135,850)**	**$ 147,340**	**$ 500,169**
Total City National Holdings		**22,270,765**	**$ 22,850,558**		**$ 22,862,045**	**$ (135,850)**	**$ 147,340**	**$ 500,192**
Estimated Accrued Income					$ 114,377			
Total of City National Investments					**$ 22,976,422**			
					Unrealized G/L of Market Value		$ 11,487	
Mandatory 3 CDs - Assigned to DMHC								
Banc of California - # 3030018015 - Mat 8/3/2017 - 0.55%	8/3/16	1	$ 100,000	$ 100,000	$ 100,000	$ -	$ -	$ 550
City National Bank - # 432928519 - Mat - 10/16/2017 - 0.10%	10/16/16	1	$ 100,000	$ 100,000	$ 100,000	$ -	$ -	$ 100
TransPacific National Bank # 1507765 - Mat 9/23/17 - 0.30%	9/26/16	1	$ 100,000	$ 100,000	$ 100,000	$ -	$ -	$ 300
Total of Time Deposits			**$ 300,000**		**$ 300,000**		**$ -**	**$ 950**
Total of Investments			**$ 24,877,302**		**$ 24,888,788**		**$ 147,340**	**$ 512,090**

City National Rochdale
INVESTMENT MANAGEMENT

San Francisco Health Authority –
Portfolio Review Snapshot as of 9/30/16

City National Rochdale

1) Market Value **as of** **8/31/2016** **9/30/16** **Change** **Monthly Accrued Interest** **Bond Par Amount**

a. Market Value: $22,956,813 $22,976,422 $19,609 $40,228 $ 22,193,325

2) Historical Total Return Performance as of 9/30/16:

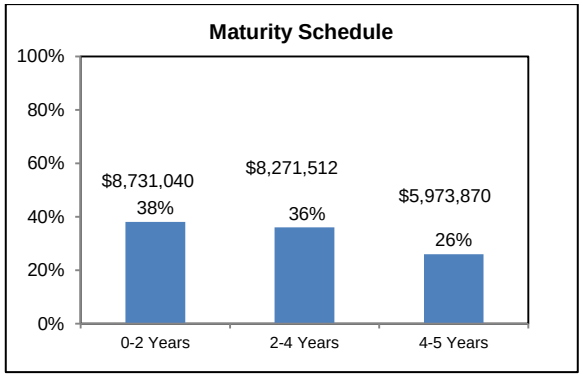
Time Period	Portfolio	Barclays 1-5 Year Gov't/Credit
September 2016	0.11%	0.15%
Fiscal YTD (6/30/16 - 9/30/16)	0.12%	0.04%
Inception to Date (5/31/12 - 9/30/16)	2.33%	1.49%

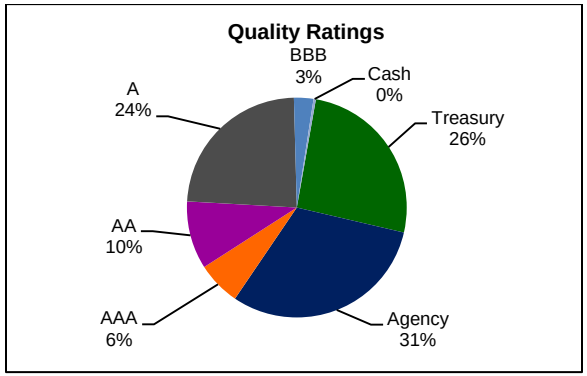
Gains & Income

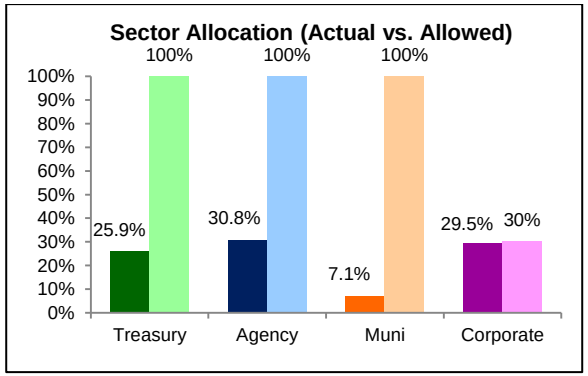
YTD Realized G/L	$66,736
Unrealized G/L	$135,836
YTD Interest Income	$410,179
FYTD Interest Income	$124,757

Portfolio Structure

a. Yield to Maturity	1.24%
b. Average Maturity	2.68 years
c. Weighted Average Coupon	2.17%
d. Average Credit Quality	AA+







3) Credit Issues (Investment rating downgrades during the period)

a. There were no credit issues for the month of September.

9/30/2016

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City National Rochdale
INVESTMENT MANAGEMENT

Definition of Terminology

1) Portfolio Structure Terms[i]

a. **Coupon Rate:** The interest rate promised in a contract; this is the rate used to calculate the cash flows the investors will receive.
b. **Credit:** With respect to borrowing, the willingness and ability of the borrower to make promised payments on the borrowing.
c. **Credit Analysis:** The evaluation of credit risk: the evaluation of the creditworthiness of a borrower or counterparty.
d. **Maturity:** The date when a bond matures, returns principal borrowed, and makes the final coupon payment.
e. **Weighted Average:** An average in which each observation is weighted by an index of its relative importance. In terms of a portfolio, the weight is based on each asset's current market value.
f. **Yield to Maturity:** The annual return that an investor earns on a bond, if the investor purchases the bond today and holds it until maturity. It takes into account the cash flow the investor receives as well as the adjustment of a bond's premium or discount.

2) Credit Quality Ratings[ii]

a. **Treasury:** A United States Treasury obligation.
b. **Agency:** A United States Government Agency obligation, for example Fannie Mae.
c. **A-1:** Superior ability for repayment of senior short-term debt obligations. (Taxable)
d. **SP-1:** Best quality protection for repayment of senior short-term (one year or less) debt obligations. (Tax-Free)
e. **AAA:** Cash and highest quality securities that have an extremely strong capacity to meet financial obligations. (Investment Grade)
f. **AA:** Slightly lower credit protection measures than AAA rated bonds, but AA rated bonds still have a very strong capacity to meet financial obligations. (Investment Grade)
g. **A:** Lower than AA rated bonds, An A rated bond provides adequate credit protection measures and possess a strong capacity to meet financial obligations. (Investment Grade)
h. **BBB:** Lower than A rated bonds, a BBB bond provides adequate credit protection measures at present time, significant adverse conditions may weaken capacity to meet financial obligations. (Investment Grade)

[i] Definitions are cited from the CFA Institute's Program Curriculum.
[ii] Credit Quality Ratings are cited from the disclosures section of your investment statement.

9/30/2016

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Agenda Item 4:

Chief Medical Officer's Report

Action Items:

a. Review and Approval of Proposal to Rollover 2013 Practice Improvement Program (PIP) Funds

b. Review and Approval of PIP CY 2017 Funding

Discussion Items:

c. HEDIS and CAHPS Results Report

d. Beacon Health Options and Adult Non-Specialty Mental Health Utilization Update

e. Access to Care Dashboard

SAN FRANCISCO HEALTH PLAN™

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SAN FRANCISCO HEALTH PLAN
Here for you

Action Item:

Review and Approval of Proposal to Rollover

2013 Practice Improvement Program (PIP) Funds

SAN FRANCISCO HEALTH PLAN
Here for you

MEMO

201 Third Street, 7th Floor • San Francisco, CA 94103
(415) 547-7800 • FAX (415) 547-7821 • www.sfhp.org

Date: October 25, 2016

To	**SFHP Finance Committee and Governing Board**
From	**James Glauber, MD, MPH, Chief Medical Officer**
Regarding	**Department of Public Health Clinics' Unused PIP Block Funds**

Recommendation

San Francisco Health Plan (SFHP) recommends that San Francisco Health Network's (SFHN) unused grant funds from 2013 of $534,648 be rolled over into the new Strategic Reserves Grants for fiscal year 2016-2017. Department of Public Health (DPH) Clinics are currently eligible for $1,632,222 for the Strategic Reserves Grant program. With approval to roll over the unused 2013 Practice Improvement Block Funding Program funds, DPH Clinics would be eligible for a total of $2,166,870 to implement strategies to improve access to health care services for SFHP members.

Background

SFHP created the Practice Improvement Program (PIP) Block Funding Program in 2013 to provide financial resources to support infrastructure improvement in patient access, utilization, and data quality. For that program, the DPH Clinics identified a project that met the program criteria at the time. However, the DPH budget and finance leadership could not agree to support the long-term costs of the project. Thus, a final project could not be approved for implementation by DPH. Additionally, every other medical group has spent their allotted PIP Block Funding Program funding.

In July of 2015, SFHP and SFHN collaborated on an access improvement work plan. In support of the work plan, SFHP agreed to allow SFHN to use funds from the 2013 PIP Block Funding Program. While the access improvement plan was implemented, there are 2013 PIP Block Funding Program funds still available for DPH Clinics.

	Initial Funding Amount	Amount Dispersed to Date	Estimated Funds Remaining
DPH Clinics	$1,000,632	$467,470	$534,648

Recommendation

SFHP recommends that SFHN's unused funds be rolled into the new Strategic Reserves Grants for fiscal year 2016-2017. DPH Clinics are currently eligible for $1,632,222 for the Strategic Reserves Grant program. With approval to roll over the unused funds listed above, DPH Clinics would be eligible for a grand total of $2,166,870.

SAN FRANCISCO HEALTH PLAN
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Action Item:

Review and Approval of Practice Improvement Program (PIP) Funding for CY 2017

Values in Funding PIP

SAN FRANCISCO HEALTH PLAN
Here for you

- Ensure PIP funding remains at a meaningful level to incentivize change
  - Overcome limitations of initial health assessments and other large practice improvement programs, where cost of reporting can be more than the benefit of the incentive
  - Provide a funding stream to support improvement initiatives in our network
- Maintain partnership and goodwill
  - Nearly 100% network participation
  - Collaborative measure development
  - No “take-aways” – PIP has never been funded through a rate cut
- Support the San Francisco Safety Net
  - PIP funding is beneficial to network FQHCs

Practice Improvement Program
Partnering to prepare for the future

Recommendation for PIP contributions for CY 2017:

	2016	Recommendation for 2017
Medi-Cal Population	18.5%	18.5%
Healthy Kids	5%	5%

HEDIS vs. CAHPS

SAN FRANCISCO HEALTH PLAN
Here for you

	HEDIS	CAHPS
What does it assess?	Assess clinical quality	Assess member experience
Why does it matter?	Measures preventive care, impacts members' health, determines auto assignment, DHCS Quality Awards, NCQA Accreditation	Member experience impacts member health, NCQA Accreditation
How is the data collected?	Claims & encounters, Chart review, Lab feeds, and EMR data	Self-reported survey

HP-CAHPS Results

SAN FRANCISCO HEALTH PLAN

Rating	2015 Results	2016 Results	NCQA Percentile
Rating of Personal Doctor	**75.5%**	**75.7%**	Below 25th
Rating of Specialist	**73.4%**	**76.5%**	25th
Rating of All Health Care	**64.8%**	**68.3%**	Below 25th
Rating of Health Plan	**64.2%**	**67.8%**	Below 25th
Getting Needed Care (organizational goal)	**62%**	**66.1%**	Below 25th
Getting Care Quickly (organizational goal)	**66%**	**65.4%**	Below 25th
Customer Service	**74.4%**	**80.7%**	Below 25th
Coordination of Care	**77.5%**	**83.3%**	Below 25th

CAHPS Challenges

SAN FRANCISCO HEALTH PLAN

- Decreasing response rates
- Only available in English and Spanish
- Doesn’t answer the ‘why’

CAHPS Improvement Efforts

SAN FRANCISCO HEALTH PLAN

Partnering with Providers

- 2 CAHPS measures in PIP
- Strategic Reserves Grants
- Technical Assistance and Training

Internal Improvements

- Teladoc
- Access to Care Committee
- Improving monitoring and follow up

Publicly Reported Medi-Cal Measures

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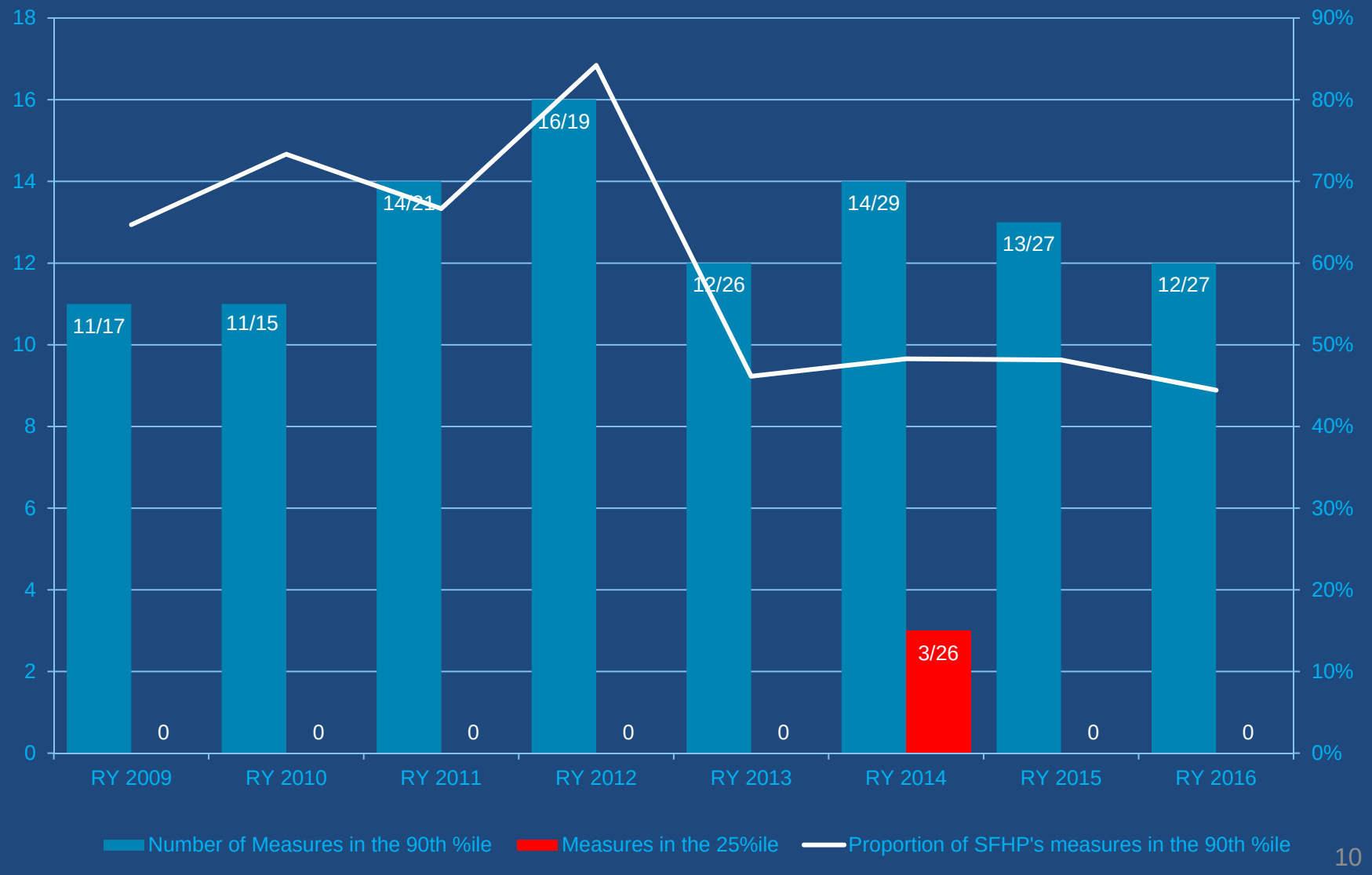
SFHP Measures Reaching the National 90th Percentile for Medicaid



MY 2015 HEDIS Performance

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HEDIS Medi-Cal Measure	%ile	Change from MY 2014
Childhood Immunizations (CIS)	**90th**	-1%
Comprehensive Diabetes Care – HbA1c test, HbA1c Control, Eye Exams, Medical Attention for Nephropathy (CDC, 5 indicators)	**90th**	-6% to 5%
Controlling High Blood Pressure (CBP)	**90th**	3%
Postpartum Care (PPC)	**90th**	4%
Weight Assessment and Counseling for Nutrition & Physical Activity (WCC, 3 indicators)	**90th**	1% to 6%
Avoidance of Antibiotics in Adults with Acute Bronchitis (AAB)	**90th**	-2%

MY 2015 HEDIS Performance

SAN FRANCISCO HEALTH PLAN

HEDIS Medi-Cal Measure	%ile	Change from MY 2014
Comprehensive Diabetes Care – HbA1c blood pressure (CDC)	75th	-4%
Prenatal Care (PPC)	75th	0%
Well Child Visits (W34)	75th	-3%
Medication Management for People with Asthma (MMA, 2 indicators)	75th	5%
Use of Imaging Studies for Low Back Pain (LBP)	75th	-5%

MY 2015 HEDIS Performance

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HEDIS Medi-Cal Measure	%ile	Change from MY 2014
Cervical Cancer Screening (CCS)	50th	-12%
Immunizations for Adolescents (IMA)	50th	-3%
Labs for Patients on Persistent Meds - ACE/ARBs, Digoxin (MPM, 3 indicators)	50th	0% to 4%

HEDIS Challenges

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- Data quality
- New NCQA measures
- Large number of measures
- Staff training

HEDIS Improvement Efforts

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Partnering with Providers

- Practice Improvement Program (PIP)
- Data quality monitoring

Partnering with Members

- Incentives,
- Disease Management program

Internal Process Improvements

- Full-Time HEDIS Nurse
- Measure prioritization structure

CMO Report

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Beacon Health Options and Adult Non-Specialty Mental Health Update

2016 Adult Non-Specialty Mental Health Penetration Rate through September

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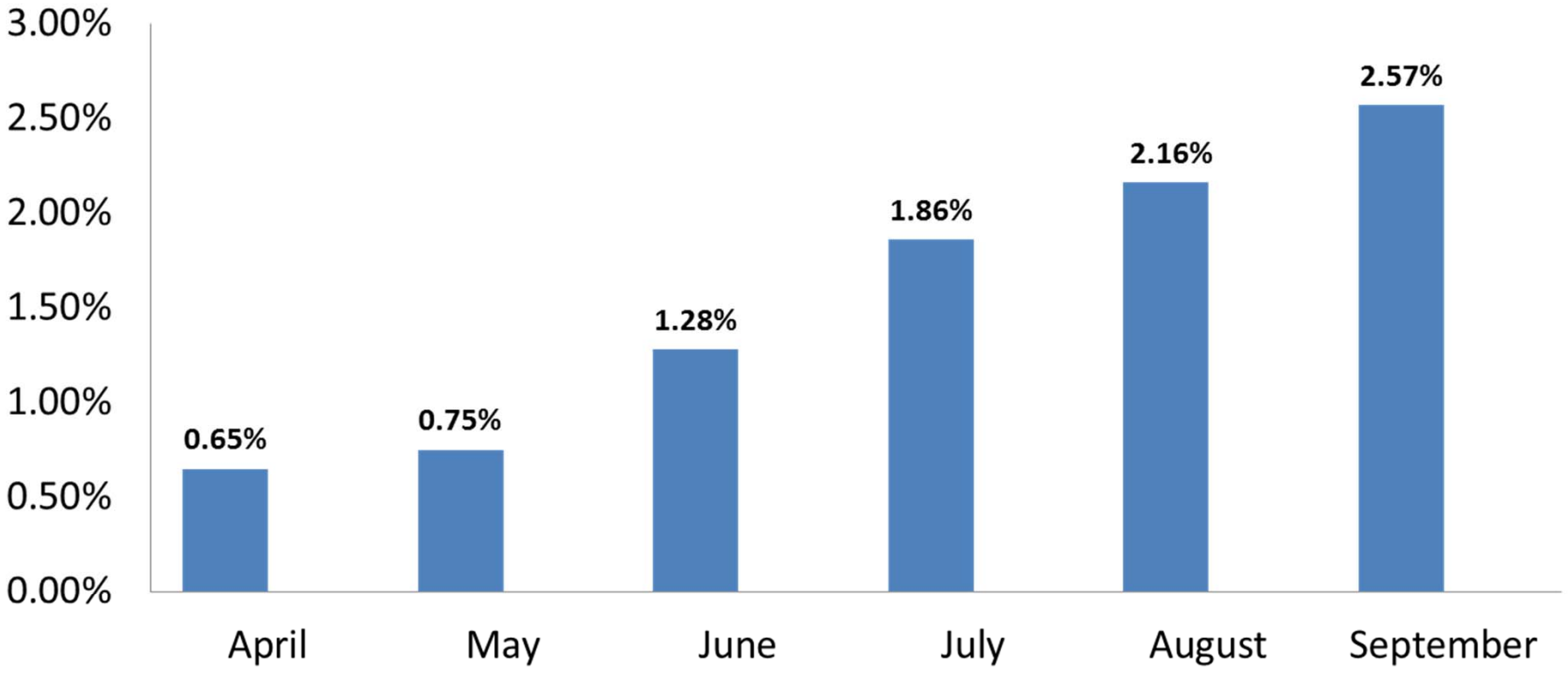

CMO Report

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Access to Care Dashboard: Primary Care

Access to Care: Primary Care Access Measures

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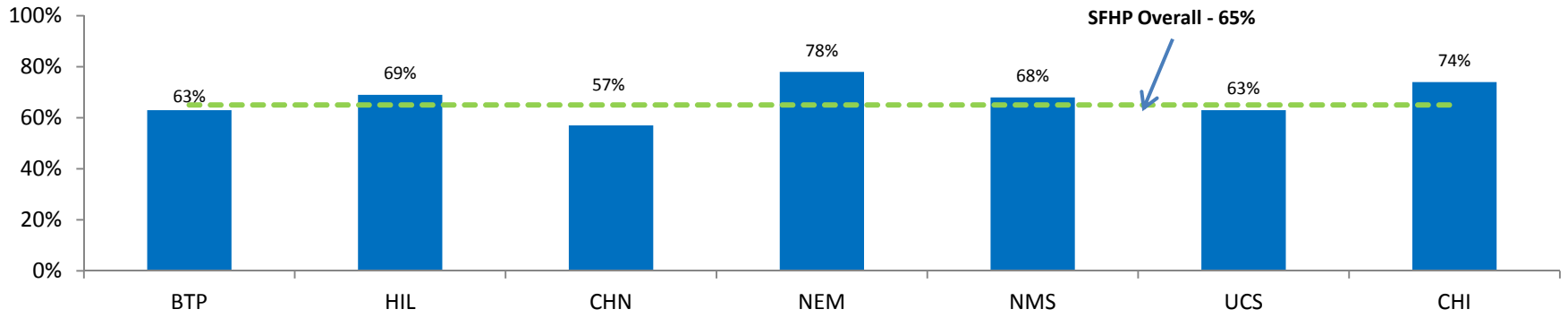
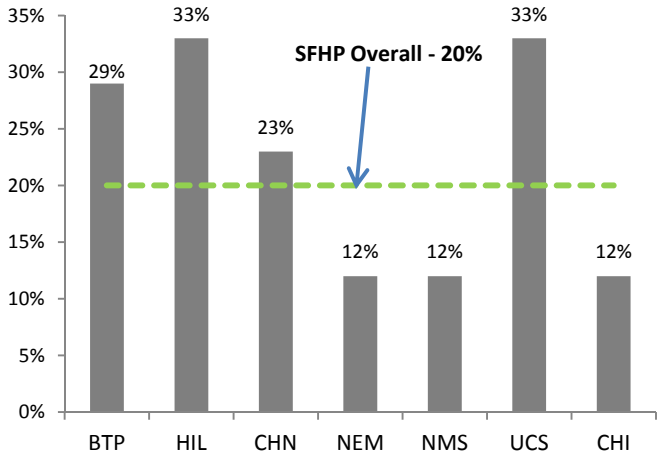
% Members With at Least 1 PCP Visit in 12 Months by Medical Group

(DOS: 04/2015-03/2016) Members with 12 months eligibility ONLY



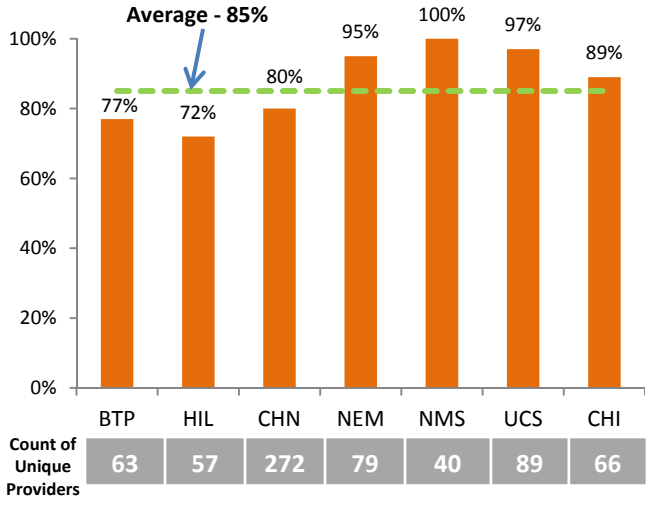
% Members With At Least 1 ED Visit in 12 months

(DOS: 04/2015-03/2016)
Members with 12 months eligibility ONLY



% PCP Panels Accepting New Patient*

As of 08/08/2016

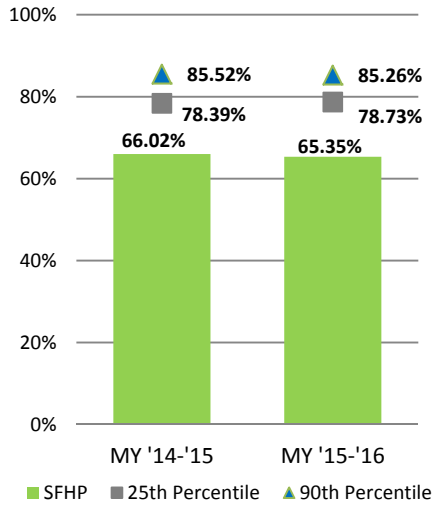


Count of Unique Providers	BTP	HIL	CHN	NEM	NMS	UCS	CHI
	63	57	272	79	40	89	66

*All data for open and closed panels is as reported to SFHP from the Network

CAHPS: Getting Care Quickly:

% Answering Usually or Always*



*Medical Group Level Information Not Available

Agenda Item 5:
Discussion Item:

- Discussion of Five-Year Hepatitis C Utilization Projections

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MEMO

Date:	**October 25, 2015**
To:	**Governing Board**
From:	**John A. Gregoire, Chief Financial Officer** **Lisa Ghotbi, Pharm.D., Director, Pharmacy Services**
Regarding:	**Hepatitis C - Five Year Projections of Pharmacy Costs - Updated**

This item is updated from prior presentation and is presented to the San Francisco Health Plan (SFHP) Governing Board for information only. No action by the Board is required.

SFHP presents the Governing Board with a five-year (2016-2021) estimated financial impact of Hepatitis C medications to support SFHP planning for the increasing medical expenses and to describe potential next steps to monitor and manage the treatment of Hepatitis C.

Model Overview: SFHP developed a model to identify all currently eligible members with any diagnosis of Hepatitis C in claims history and establish prevalence estimates. FY2015-16 treatment experience was used in the model and adjusted for new medication treatment guidelines to project treatment patterns through June 2021. The model uses current drug pricing, which is a 23.4% reduction retroactive to July 1, 2016.

Model Assumptions:

- Kaiser Medi-Cal membership is excluded.
- Healthy Worker membership is excluded.
- Treatment has slowed over the last 3 months so model has been updated with fewer Hep C members treated at the five year point. Of the 5,131 members with a Hepatitis C diagnosis (4.05% prevalence), model treatment for 71% or 3,661 members.
- Drug selection is modeled based on prescribing preferences over past 3 months: Epclusa® 12 week treatment for 51% of members, Harvoni® 8-24 weeks treatment for 32% of members, 15% of members receive Zepatier® and 2% receive Daklinza/Sovaldi. An estimated 10% of members will require treatment for 24 weeks.

- The model predicts a kick payment reduction from the Department of Health Care Services (DHCS) to $6,121.25 per treatment week as of July 2016 expanded to include Zepatier® and Epclusa®.
- The model predicts a DHCS treatment guideline change to mirror AASLD criteria as of November 2016 resulting in more members treated per month.
- The model does not project long-term medical cost savings to the health delivery system attributable to averted chronic liver disease outcomes.

MODEL PROJECTIONS

Treatment Projections: Prevalence of Hepatitis C varies by category of aid with an overall identified prevalence of 4.05%. As of July 2016, 10.6% of the members identified with Hepatitis C (Hep C) have been treated at a cost of $55 million (not including rebates or supplemental kick payments).

Table 1: SFHP Medi-Cal (MC) members (non-Kaiser) eligible as of 10/2016

SFHP MC Members	Hep C Mbrs	All Mbrs	Hep C Prevalence	Already treated	% Already Treated
All other -Adult 19/Child 18 BCCTP &	691	57,549	1.20%		
Disabled (Disabled and Dual Coverage	2,274	12,553	18.12%		
Expansion	2,166	56,614	3.83%		
All Medi-Cal (Non-Kaiser)	5,131	126,716	4.05%	545	10.6%

This model estimates that next June 2017 will be the peak of Hep C treatment with 100 new starts per month, 322 members in treatment translating to 1260 treatment weeks per month.

Chart 1: Projections of SFHP MC Members receiving Hepatitis Treatment

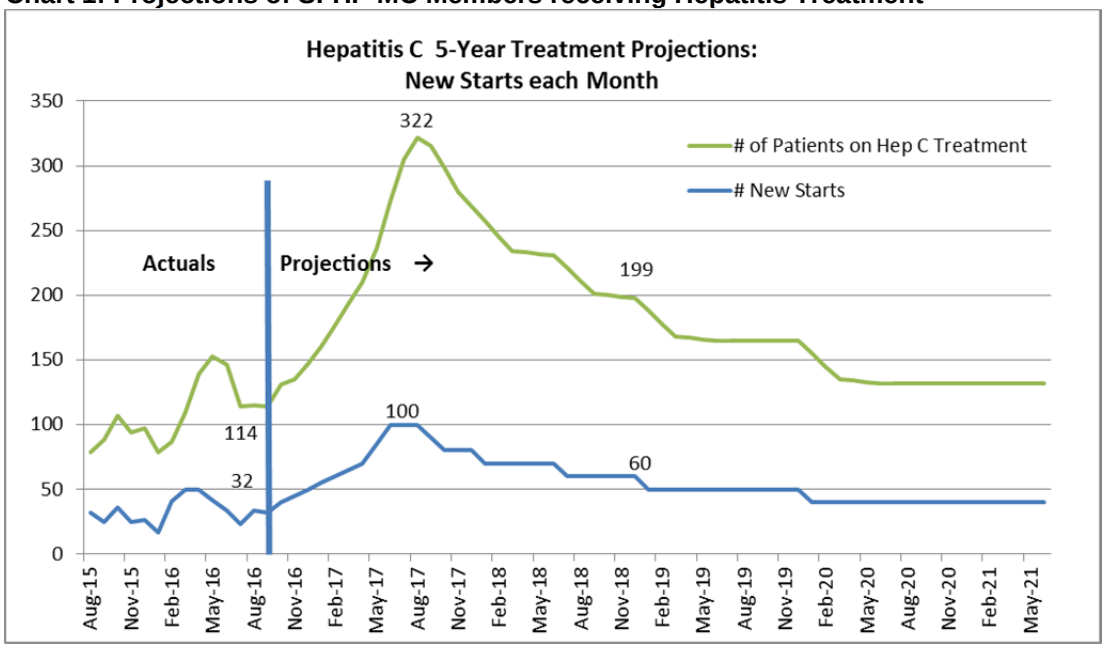
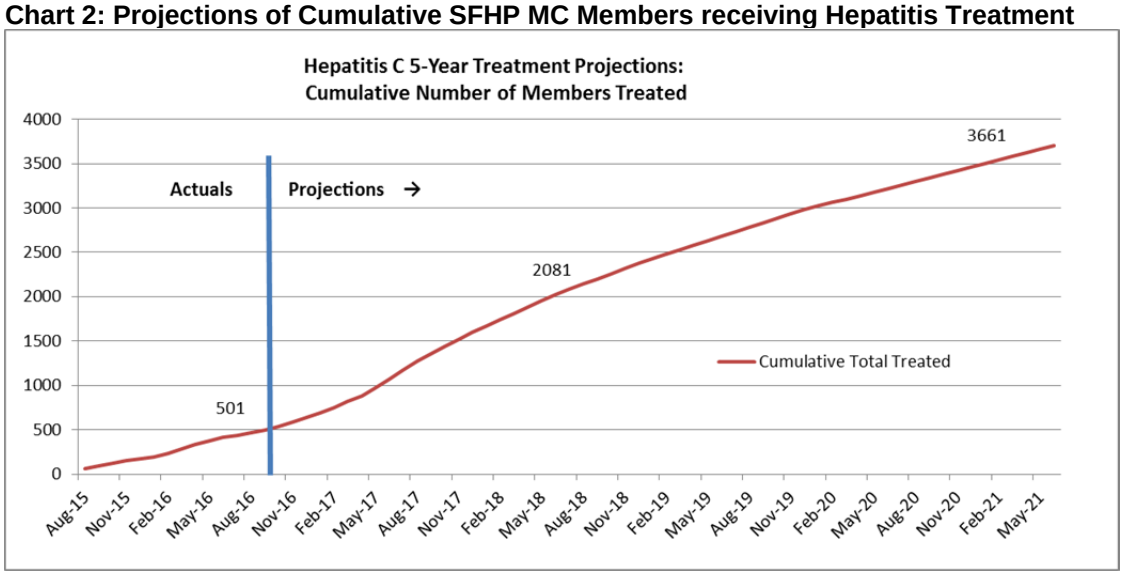


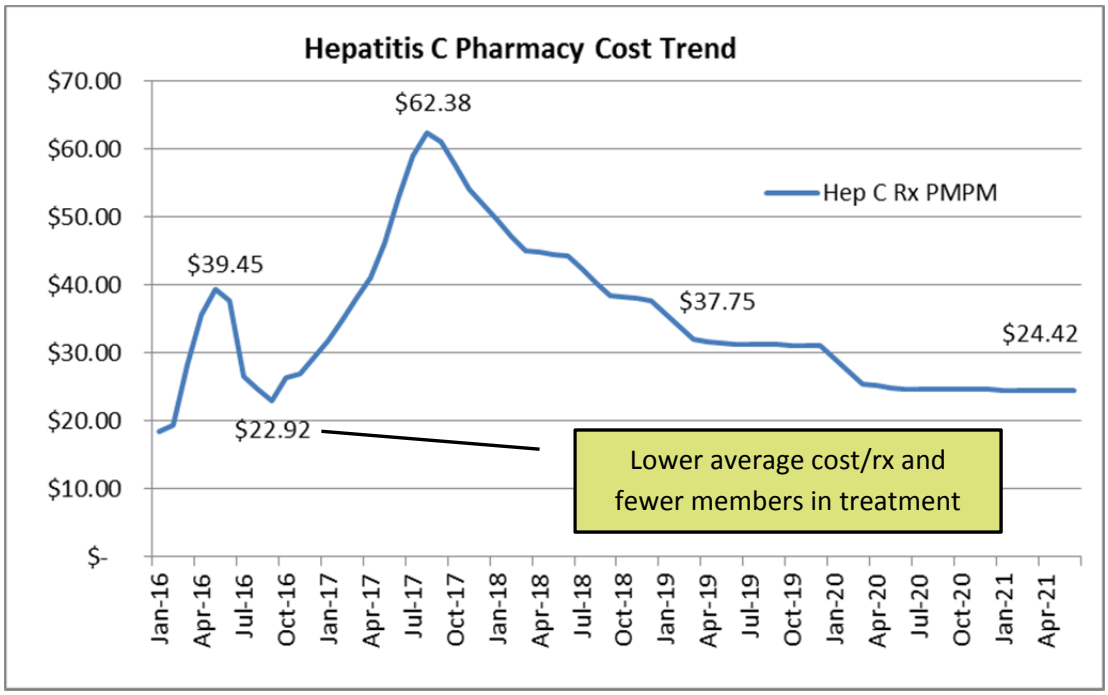
Chart 2: Projections of Cumulative SFHP MC Members receiving Hepatitis Treatment



Utilization will begin to gradually decline by the fourth quarter in 2017 as the untreated pool of members begins to dwindle. A low level of Hepatitis C treatment is expected to continue beyond this five-year model.

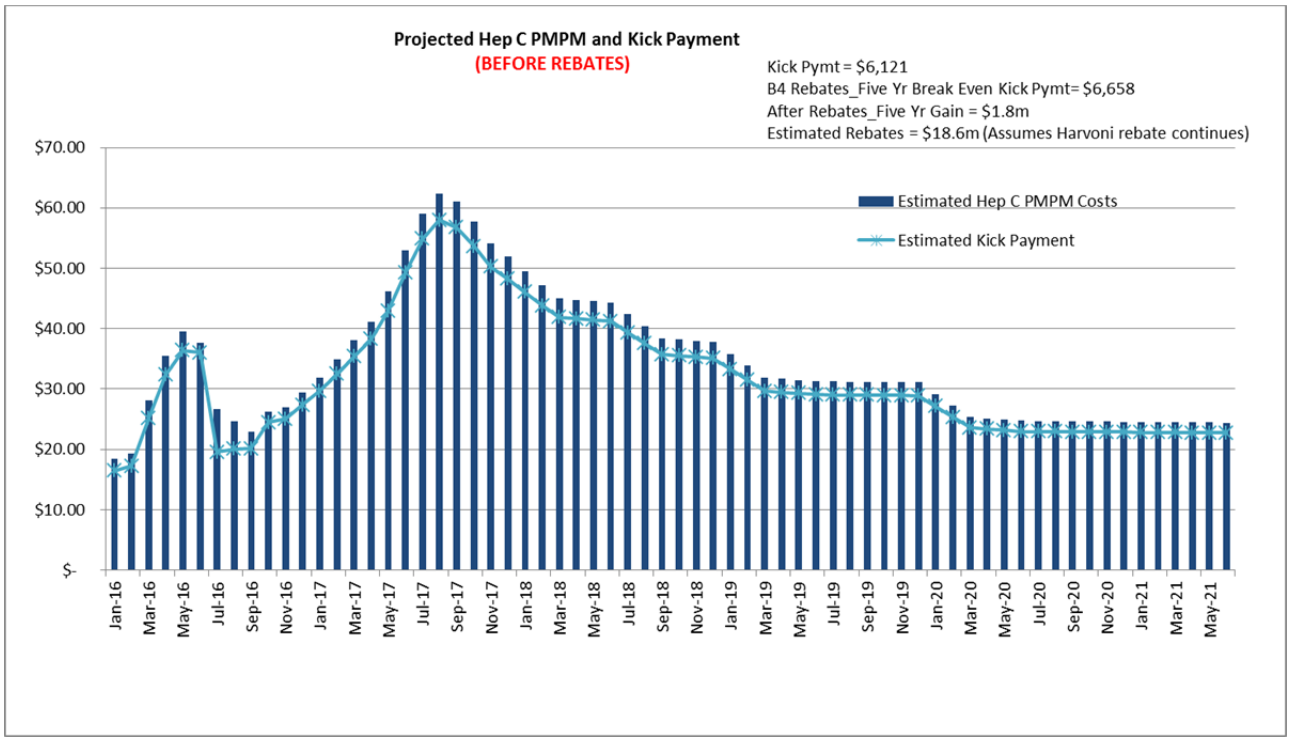
Cost Projections - The new Hepatitis C medication, Epclusa® (at $74K per 12 weeks) will likely dominate as the preferred treatment since there are no genotype or resistance testing requirements.

Table 2: SFHP MC (non-Kaiser) projected costs for Hepatitis C.



Current projections suggest a gap between Hepatitis C PMPM costs and the supplemental kick payments. The cumulative five year cost for Hepatitis C medications is estimated at **$306.8 Million**. The estimated supplemental kick payment is **$283.7 million**. This leaves a gap of **$23 million** that will need to be managed through negotiated rebates, preferred drug selection (promoting Zepatier® when possible), and possibly collaboration on pricing for 340b eligible claims.

Table 3: SFHP MC (non-Kaiser) Projected PMPM



Next Steps:

1) Continue monitoring Hepatitis C expenses and update projections quarterly.
2) Develop a plan to close any financial gap between drug costs to SFHP and the supplemental kick payment from DHCS.
3) Consider modeling the potential savings after Hepatitis C treatment attributable to averted chronic liver disease outcomes.

Agenda Item 6:
Discussion Item

- Member Advisory Committee Report

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MEMO

Date: October 21, 2016

To	**Governing Board**
From	Valerie Huggins (415) 615-4235 Fax: (415) 615-6435 Email: vhuggins@sfhp.org
Regarding	Member Advisory Committee Materials

Enclosed are the minutes and agenda for the September and October 2016 Member Advisory Committee meeting.

Please direct any questions to Maria Luz Torre and Irene Conway, co-chairs of the Members Advisory Committee.

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MEMBER ADVISORY COMMITTEE
SAN FRANCISCO HEALTH AUTHORITY
www.sfhp.org
Valerie Huggins
Phone: (415) 615-4235 /Email: vhuggins@sfhp.org
Maria Luz Torre (415) 722-6229 & Irene Conway, Co-Chairs

Meeting Agenda
September 9, 2016
1:00PM- 3:00PM
San Francisco Health Plan
(United Way Building)
550 Kearny Street, 1 FL Board Room A 7380
San Francisco, CA 94108

1. Welcome, Introductions & Roll Call

2. Adopt Agenda/Approve Minutes

3. Reports
- Chairs & Governing Board: Maria Luz Torre & Irene Conway
- Quality Improvement Committee: Edward Evans & Irene Conway
- Staff Report: John Grgurina, Jr. CEO

4. Discussion: Speaker from Supervisor Kim's Office; Public Health and Board Policies

5. Public Comment:

6. Calendar Items For Next Meeting:

7. Announcements:

8. Other:

9. Adjournment:

Please Note These Upcoming SFHA Meetings:

Quality Improvement Committee:	October 6, 2016 (7:30am-9am)
Members Advisory Committee	October 7, 2016 (1pm-3pm)
Finance Committee:	November 2, 2016 (11am-12pm)
Governing Board:	November 2, 2016 (12pm-2pm)

****

The Committee meetings are public and wheelchair accessible. The Committee requests accommodations for those with allergies or chemical sensitivity. Please refrain from the wearing of scented products. Also, during the meeting please make sure all cell phones and pagers are off. Thank you for your cooperation.

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September 9, 2016
Member Advisory Committee
Meeting Minutes

Members Present:

Members Absent:

Guests: Christopher Vasquez from Supervisor Jane Kim Office

Staff: Valerie Huggins, Stephanie Boyce, and John Grgurina

1. **Welcome, Introductions and Roll Call:**
   The meeting was called to order at 1:00pm.

2. **Approval of Agenda & Minutes:**
   The agenda was approved and minutes from August 5, 2016 were approved as written.

3. **Committee Reports:**
   Chair & Governing Board Report-Maria Luz Torre & Irene Conway
   Irene Conway and Maria Luz Torre reported that the Board met on Wednesday, September 7, 2016. The next scheduled meeting is November 2, 2016.

   The Chairs continues to reiterate to members the importance of Committee rules which outlines among other things attendance and participation. These rules were fully discussed and approved by members. The goal of the rules is to make our meetings efficient, productive and these outline the obligations of members to the Committee. It applies equally to all members.

   Quality Improvement Committee Report-Ed Evans and Irene Conway
   Ed Evans and Irene Conway both reported that the Quality Improvement Committee met on August 11, 2016. The Committee discussed grievances and the importance of filing grievances. On the pharmacy side there has been a change in the Hepatitis C formulary.

   Ms. Conway reported that there are new incentives for SFHP members. For example, there are two incentives for diabetes: $25 for screening, and $25 for taking an eye exam. Other incentives include $50 for child immunizations before two years old, blood pressure screening, asthma, well child visits and more.

   Ms. Conway suggested that for the October meeting, we bring in SFHP staff to explain the different incentives and to bring in the forms that members can take to their doctor's office. These forms are supposed to be mailed to the members, but not everyone receives them in the mail. Last year in October, staff members explained and provided forms for blood pressure screening. MAC members had their providers sign the forms on their next blood pressure screening, and received a $25 Walgreens gift card.

Mr. Evans and Ms. Conway continue to remind the Committee if they have any issues with their providers to please let him or Irene Conway know.

Staff Report – John F. Grgurina, Jr., CEO
John F. Grgurina, Jr. CEO reported that Governing met on Wednesday, September 7th. Mr. Grgurina gave a few highlights of the Board meeting.

Mr. Grgurina reported that the Board approved the proposal to network expansion with Jade Medical Group and allows me to enter contract with same parameters as other contracted medical groups. The Board also approved the CEO annual performance evaluation as well fiscal year 15-16 organizational score and fiscal year 15-16 staff bonus. In addition to this, the Board approved a one-time community partner of $30K to the San Francisco-Marin Food Bank because their mission is well aligned with our mission to serve our members.

Lastly, Mr. Grgurina announced the Bay Area Medi-Cal 50 years Anniversary Celebration on October 25, 2016 from 9.30am to 11.30am. The Board and Members Advisory Committee are invited to attend this event.

Mr. Grgurina answered most of the Committee's questions.

4. **Discussion:** Christopher Vasquez, Supervisor Kim's Office
   Christopher Vasquez attended the Committee meeting to share their vision of a healthy San Francisco and California. Mr. Vasquez was able to answer most of the Committee's questions.

5. **Public Comment**
   There were no public comments.

6. **Calendar Items for Next Meeting**
   For the October meeting, there will be a presentation from SFHP staff on incentives - such as incentives/gift cards for blood pressure screening, diabetes, well child visits, childhood immunizations and more. Staff will bring in necessary forms that members can bring to their providers to fill out and sign in order to receive their gift card incentives.

7. **Announcements**
   The Co-Chairs and staff continue to remind members that their full attendance and participation at the Committee meetings are important. Any absences to be excused must be reported to staff ahead of time and must be for a valid reason. Several event announcements were made.

8. **Adjournment**
   The meeting adjourned at 3pm.

Date Approved Oct 7, 2016

Maria Luz Torre and Irene Conway, Co-Chairs

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Valerie Huggins
Phone: (415) 615-4235 /Email: vhuggins@sfhp.org
Maria Luz Torre (415) 722-6229 & Irene Conway, Co-Chairs

Meeting Agenda
October 7, 2016
1:00PM- 3:00PM
San Francisco Health Plan
(United Way Building)
550 Kearny Street, 1 FL Board Room A 7380
San Francisco, CA 94108

1. Welcome, Introductions & Roll Call

2. Adopt Agenda/Approve Minutes

3. Reports
- Chairs & Governing Board: Maria Luz Torre & Irene Conway
- Quality Improvement Committee: Edward Evans & Irene Conway
- Staff Report: John Grgurina, Jr. CEO

4. Discussion: Cassie Caravello: Project Manager, Clinical Quality – Member Incentives

5. Discussion: Dayana Chaves, Care Support Program Supervisor – Overview of Care Support Programs

6. Public Comment:

7. Calendar Items For Next Meeting:

8. Announcements:

9. Other:

10. Adjournment:

Please Note These Upcoming SFHA Meetings:

Finance Committee:	November 2, 2016 (11am-12pm)
Governing Board:	November 2, 2016 (12pm-2pm)
Members Advisory Committee	November 4, 2016 (1pm-3pm)
Quality Improvement Committee:	November 10, 2016 (7:30am-9am)

****

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October 7, 2016
Member Advisory Committee
Meeting Minutes

Members Present:

Members Absent:

Guests: SFHP Staff, Cassie Caravello and Dayana Chaves

Staff: Valerie Huggins, Stephanie Boyce, and John Grgurina

1. **Welcome, Introductions and Roll Call:**
   The meeting was called to order at 1:00pm.

2. **Approval of Agenda & Minutes:**
   The agenda was approved with one amendment; the next Quality Improvement Committee is December 8, 2016. The minutes from October 7, 2016 were approved as written.

3. **Committee Reports:**
   Chair & Governing Board Report-Maria Luz Torre & Irene Conway
   Irene Conway and Maria Luz Torre reported that the Board had no scheduled meeting. The next scheduled meeting is November 2, 2016.

   The Chairs continues to reiterate to members the importance of Committee rules which outlines among other things attendance and participation. These rules were fully discussed and approved by members. The goal of the rules is to make our meetings efficient, productive and these outline the obligations of members to the Committee. It applies equally to all members. Members were given copies of the rules for their reference.

   Quality Improvement Committee Report-Ed Evans and Irene Conway
   Ed Evans and Irene Conway both reported that the Quality Improvement Committee met on October 6, 2016.

   Mr. Evans reported that the Committee discussed grievances and the importance of filing grievances and the Committee reviewed the 2015 Quality Improvement Plan and how it's broken down in various segments for the upcoming year.

   Ms. Conway reported that Frequently Asked Questions on grievances can be found on the SFHP website in different languages. When members have any issues with providers, it is recommended that they call customer service with their complaint. Grievances are a rich source of information to the health plan. They are treated very

seriously, investigated, and have oversight from regulatory agencies. A member may also call Customer Service to report any issues, and may choose to Decline to File a grievance. The issue is still treated seriously and investigated.

Ms. Conway also reported that members have a right to a second opinion within their medical group. On the pharmacy side the flu vaccine can be administered at the pharmacies, no appointment or authorizations needed.

Staff Report – John F. Grgurina, Jr., CEO
John F. Grgurina, Jr. CEO announced the Bay Area Medi-Cal 50 years Anniversary Celebration on October 25, 2016 from 9.30am to11.30am. 2016 marks 50 years since the Medi-Cal program was created in in California. I am delighted to invite you to the Bay Area celebration of the 50th Anniversary for the Medi-Cal program. In partnership with the Department of Health Care Services, the Health Plan of San Mateo and Health Access, the San Francisco Health Plan will be commemorating this critical source of health insurance to over 250,000 residents of San Francisco and San Mateo counties.

Mr. Grgurina answered most of the Committee's questions.

4. **Discussion: Member Incentives; Cassie Caravello, SFHP Project manager**
Ms. Caravello made a presentation on the different incentives - such as gift cards for blood pressure screening, diabetes, well child visits, childhood immunizations and more. In addition to that, she brought in the necessary forms that members can bring to their providers to fill out and sign in order to receive their gift card incentives.

Ms. Caravello answered most of the Committee questions.

5. **Discussion: Overview of Care Support, Dayana Chaves, Care Support Programs**
Ms. Chaves attended the Committee meeting to give an overview of San Francisco Health Plan (SFHP) Care Management Programs. The Care Management Programs strives to reduce reliance on acute hospital utilization while ensuring a continuum of reliable, quality health care by reinforcing ties to primary care providers, focusing on prevention and early intervention, and mitigating social and economic barriers to care.

SFHP provides Care Coordination by assisting members with the following Services:

- Assessment Care Plan and Interventions
- Connecting Establishing Primary Care
- Accompanying to Appointments (transportation)
- Collaborating and Planning
- Connecting to Social Services

The Care Management Programs offer the following for Community Health Network and UCSF Medical Group Network members:

- Community Base Care Management (CBCM)
- Time Limited Coordinator (TLC)
- Complex Medical Care Management (CMCM)
- Health Risk Assessment Care Coordination (HRACC)

Ms. Chaves answered most of the Committees questions.

6. **Public Comment**
   There were no public comments.

7. **Calendar Items for Next Meeting**
   There were no items calendared for the next meeting.

8. **Announcements**
   The Co-Chairs and staff continue to remind members that their full attendance and participation at the Committee meetings are important. Any absences to be excused must be reported to staff ahead of time and must be for a valid reason. Several event announcements were made.

9. **Adjournment**
   The meeting adjourned at 3pm.

Date Approved _____

_____
Maria Luz Torre and Irene Conway, Co-Chairs

Closed Session
Agenda Item 7:
Action Item

- Review and Approval of Medi-Cal Rates Effective January 1, 2017

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Finance Committee & Governing Board

MEMO

Date:	**October 25, 2016**
To:	**Finance Committee and Governing Board**
From:	**John F. Grgurina Jr., Chief Executive Officer and John A. Gregoire, Chief Financial Officer**
Regarding:	**Proposed Medi-Cal Rate Changes Effective January 1, 2017**

Recommendation:

San Francisco Health Plan (SFHP) recommends that the Finance Committee and Governing Board approve the attached realignment of provider Medi-Cal rates to match the State's rates paid to SFHP as reflected in the following table. The overall weighted average change is an increase of 1.5%. The range for SFHP providers is a decrease of 0.4% to an increase of 5.9%. The range is due to the differences in the distribution of membership by aid category. If approved, the proposed rate changes would be effective January 1, 2017.

Proposed Rate Changes

	----------MEDI-CAL CATEGORY OF AID----------								
	ADULT 19	CHILD 18	SPD	SPD	AGED	DISABLED			AIDS
DESCRIPTION	& OVER	& UNDER	AGED	DISABLED	DUAL	DUAL	BCCTP	AIDS	DUAL
MEMBERS - SEP 2016	14,915	36,146	3,740	8,972	4,145	2,492	19	977	163
PROPOSED RATE	$ 173.57	$ 78.53	$466.80	$ 466.80	$95.63	$ 95.63	$961.01	$ -	$ -
CURRENT RATE	$ 164.61	$ 70.10	$557.59	$ 425.58	$70.98	$ 103.99	$817.42	$ 811.68	$ 177.98
INCREASE (DECREASE)	$ 8.96	$ 8.42	$ (90.78)	$ 41.23	$24.65	$ (8.36)	$143.59	$(811.68)	$(177.98)
% CHANGE	5.4%	12.0%	-16.3%	9.7%	34.7%	-8.0%	17.6%	-100.0%	-100.0%

Each provider group's actual overall rate change will differ based on their own membership in each of the Medi-Cal aid code categories. Each provider group is paid the same for each aid code category. The differences in the distribution of membership by aid category, however, can cause differences in per member per month as well as overall funding changes. For example, when the Family category of aid was split into two new categories, Adult 19 and Over and Child 18 and Under, effective December 1, 2014, provider groups with a higher percentage of Adult 19 and Over members experienced a larger increase while provider groups with a higher percentage of Child 18 and Under members experienced an overall decrease in capitation. Please see the attached excerpt from the December 1, 2014 capitation rate change memo for a detailed explanation.

SFHP's two fee-for-service providers, UCSF (professional and hospital) and St. Luke's (hospital only), however, are paid on a per diem basis for all Medi-Cal members regardless of category of aid. Therefore, in order to adjust their per diem rates equitably in comparison to the capitated groups, we applied the proposed capitation rate changes below to their actual memberships by aid code and calculated the impact on the per diem rate. If the proposed changes are approved, then this would result in the following fee-for-service rate changes:

January 1, 2017 Fee-for-Service Providers' Rate Change:

- 3.0% increase for UCSF (for both professional and hospital)
- 5.5% increase for St. Luke's Campus (hospital only)

Background

SFHP has received rates from the Department of Health Care Services (DHCS) which were effective on July 1, 2016. The State is still waiting for approval from the Centers for Medicare and Medicaid Services (CMS) and we are still waiting for updates regarding the impact of blending the AIDS category of aid payment into the payment for members' regular categories of aid.

Effective July 1, 2016, DHCS eliminated the AIDS supplemental premium rates to health plans. DHCS premium rate setting takes into consideration the costs associated with members with AIDS now remaining in their regular category of aid. At the request of SFHP, DHCS and its actuaries are currently reviewing the methodology used to blend the supplemental payment for AIDS into the regular categories of aid. Our hope is that after this review is completed, DHCS will agree to increase rates across all categories of aid. An update will be provided at the January 2017 Governing Board meeting.

As DHCS will pay the same premium rate for all Seniors and Persons with Disability (SPD) members (Aged and Disabled categories of aid) and the same premium rate for Dual eligible members (Aged-Dual and Disabled-Dual), SFHP has realigned its capitation rates accordingly. Under this realignment, SFHP will disburse an additional $381,000 per month in total SPD capitation and an additional $90,000 per month in total Dual capitation.

Capitation Calculation

The following are the key assumptions in setting the Medi-Cal rates:

1) SFHP's administration load is proposed at 10% (previously approved Board amount for other aid codes).
2) The Practice Improvement Program (PIP) amount of 18.5% will be set aside for PIP funding.
3) Removal of plan-responsible costs for vision, mental health, pharmacy, immunizations, community-based adult services, health education, utilization management and quality improvement.
4) Removal of "pass through" funding such as the managed care organization tax, intergovernmental transfers and public hospital rate range payments.

For detailed information please see attached spreadsheet.

Overall Estimated Provider Rate Effective January 1, 2017 (Changes based on September 2016 enrollment):

SFHP overall	1.5%
Hill Physicians	5.9%
St. Luke's	5.5%
B&TMG	5.0%
CCHCA	3.5%
UCSF	3.0%
SFCCC	2.5%
NEMS/CPMC	2.0%
NEMS/SFGH	0.9%
Clinical Practice Group	-0.1%
SFGH	-0.4%

EXCERPT FROM DECEMBER 1, 2014 CAPITATION RATE CHANGE MEMO

Background

(The following is provided as an example of what occurred in 2014 when the Adult and Child Category of Aid was split into two rates.)

SFHP has received rates from the Department of Health Care Services (DHCS) for July 1, 2014 (although the state is still waiting for CMS approval and we are still waiting for a few additional items). One significant change in the rates is the splitting of the Adult/Family Temporary Assistance to Needy Families (TANF) aid codes into separate rates for adults and children.

Previously SFHP was paid the same blended capitation rate and paid our providers the same rate for a member in the TANF aid codes regardless of an adult or child. Beginning July 1, 2014, however, DHCS will pay a separate rate for Adults 19 & over and another Child rate for children 18 years and under. We will be realigning our aid code payments with our providers as of December 1, 2014. We are unable to make this change retroactive to July as health plans are precluded from reducing any rates retroactively and must give providers a 60-day notice before reducing rates. With the split in TANF aid codes, the Child rate will be a decrease of 44% from the current blended rate, while the Adult rate will increase by 70% from the current blended rate. This change in splitting the rate will cause an overall reduction for Hill Physicians and St. Luke's Hospital and a slight decrease for Brown and Toland Medical Group (B&T MG).

SFHP average TANF split adult/child:

- SFHP overall 1.7 children for each adult
- Hill Physicians 3.0 children for each adult
- B&TMG 2.2 children for each adult
- St. Luke's 2.8 children for each adult

Capitation Calculation

The following are the key assumptions in the setting of Medi-Cal rates:

5) SFHP's administration load is proposed at 10% (previously approved Board amount for other aid codes).
6) The Practice Improvement Program (PIP) amount of 18.5% will be set aside for PIP funding, similar to the practice with other Medi-Cal aid codes. The PIP funding for the Healthy Families Program transition children, or Targeted Low-Income Children (TLIC), will be maintained at 7.5%.
7) Removal of plan-responsible costs for vision, mental health, pharmacy, immunizations, health education, utilization management and quality improvement.
8) Removal of "pass through" funding such as managed care organization tax, intergovernmental transfers, and public hospital rate range payments.

Overall Estimated Provider Rate Change for 12/1/14, based on July 2014 enrollment:

SFHP overall	7.1%
SFGH/DPH	9.4%
Clinical Practice Group	9.0%
NEMS/CPMC	8.6%
CCHCA	5.2%
CPMC/St. Luke's	5.1%
SFCCC	3.7%
UCSF	2.3%
B&TMG	-0.8%
St. Luke's	-4.5%
Hill Physicians	-8.0%

PROPOSED CAPITATION RATE CHANGES EFFECTIVE JANUARY 1, 2017	**ADULT**	**CHILD/TLIC**	**SPD**	**SPD**		**AGED**	**DISABLED**		**AIDS**
	19 & OVER	**18 & UNDER**	**AGED**	**DISABLED**	**BCCTP**	**DUAL**	**DUAL**	**AIDS**	**DUAL**
SFHP ADMINISTRATIVE RETENTION PERCENTAGE	**10%**	**10%**	**10%**	**10%**	**10%**	**10%**	**10%**	**10%**	**10%**
GROSS PREMIUM RATE TO SFHP EFFECTIVE JUL 2016	$ 207.41	$ 107.21	$ 723.55	$ 723.55	$ 1,138.57	$ 192.65	$ 192.65	$ -	$ -
LESS: MCO TAX	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET PREMIUM RATE TO SFHP EFFECTIVE JUL 2016	$ 207.41	$ 107.21	$ 723.55	$ 723.55	$ 1,138.57	$ 192.65	$ 192.65	$ -	$ -
MATERNITY KICK (AVG PMPM REVENUE FOR FY16-17 THRU SEP)	$ 39.43	$ 0.83	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HEP C REIMB (AVG PMPM REV JAN THRU SEP 2016 USING 7/1/16 HEP C RATE)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ 246.84	$ 108.04	$ 723.55	$ 723.55	$ 1,138.57	$ 192.65	$ 192.65	$ -	$ -
LESS:									
CAP-VISION	$ 0.58	$ 1.14	$ 0.57	$ 0.57	$ 0.57	$ 0.58	$ 0.58	$ -	$ -
MENTAL HEALTH (FROM BLUE BAR RATE SHEETS)	$ 4.50	$ 4.99	$ 8.88	$ 8.88	$ 6.67	$ -	$ -	$ -	$ -
HOME AND COMMUNITY-BASED SERVICES (FROM BLUE BAR RATE SHEETS)	$ 0.30	$ 0.02	$ 9.31	$ 9.31	$ 5.79	$ 70.44	$ 70.44	$ -	$ -
PHARMACY EXCL HEP C (JAN-SEP 2016 PLUS 8% FOR COST/UTIL INCREASES)	$ 39.23	$ 8.59	$ 141.37	$ 141.37	$ 46.70	$ 2.77	$ 2.77	$ -	$ -
PHARMACY HEP C INCLUDING DAKLINZA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
IMMUNIZATIONS (AVG PMPM FY16-17 THRU SEP)	$ 0.18	$ 0.18	$ 0.46	$ 0.46	$ 0.18	$ 0.18	$ 0.18	$ -	$ -
HEALTH EDUCATION (FY16-17 BUDGET)	$ 0.32	$ 0.32	$ 2.01	$ 2.01	$ 0.32	$ 0.32	$ 0.32	$ -	$ -
UTIL MGMT/QUAL IMPROV (FY16-17 BUDGET)	$ 3.47	$ 3.47	$ 21.79	$ 21.79	$ 3.47	$ 3.47	$ 3.47	$ -	$ -
TOTAL MEDICAL EXPENSE	$ 48.58	$ 18.71	$ 184.39	$ 184.39	$ 63.70	$ 77.76	$ 77.76	$ -	$ -
LESS: ADMINISTRATIVE RETENTION	$ 24.68	$ 10.80	$ 72.36	$ 72.36	$ 113.86	$ 19.27	$ 19.27	$ -	$ -
	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	0.00%	0.00%
1/1/17 CAP RATE INCL 10% AND 8.5% INCENTIVES	**$ 173.57**	**$ 78.53**	**$ 466.80**	**$ 466.80**	**$ 961.01**	**$ 95.63**	**$ 95.63**	**$ -**	**$ -**
7/1/16 CAP RATE INCL 10% AND 8.5% INCENTIVES	$ 164.61	$ 70.10	$ 557.59	$ 425.58	$ 817.42	$ 70.98	$ 103.99	$ 811.68	$ 177.98
INCREASE (DECREASE)	**$ 8.96**	**$ 8.42**	**$ (90.78)**	**$ 41.23**	**$ 143.59**	**$ 24.65**	**$ (8.36)**	**$ (811.68)**	**$ (177.98)**
% INCREASE (DECREASE)	5.4%	12.0%	-16.3%	9.7%	17.6%	34.7%	-8.0%	-100.0%	-100.0%

Agenda Item 8:

- Report on Closed Session Action Items

  (Verbal report only)

SAN FRANCISCO HEALTH PLAN™

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Agenda Item 9:
Discussion Item

- CEO Report

  SF Covered MRA (formerly Bridge to Coverage), Health Homes, Pharmacy Benefit Management Contract Extension, and Business Continuity Plan Update

SAN FRANCISCO HEALTH PLAN™

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MEMO

Date:	**October 25, 2016**
To:	**Governing Board**
From:	**John F. Grgurina, Jr., Chief Executive Officer**
Regarding:	**CEO Report for November 2, 2016 Meeting**

STATE UPDATE

Medi-Cal 50th Anniversary Celebration

On October 25th, San Francisco Health Plan (SFHP), the Health Plan of San Mateo (HPSM), the Department of Health Care Services (DHCS) and Health Access are sponsoring the Bay Area celebration of the 50th Anniversary of Medi-Cal. Zuckerberg San Francisco General Hospital (ZSFGH), the largest provider of hospital-based services to San Francisco's Medi-Cal members, will be our host. Jennifer Kent, the Director of the DHCS, State Senator Mark Leno (D- San Francisco) and Assembly member Rich Gordon (D- San Mateo), as well as Medi-Cal members, providers and county partners will mark the critical importance of the Medi-Cal program to the more than 250,000 beneficiaries of San Francisco and San Mateo.

We hope the Governing Board members were able to join the celebration.

SAN FRANCISCO HEALTH PLAN STRATEGIC ANCHORS

Strategic Anchor 1: Universal Coverage

Healthy San Francisco Program Enrollment as of September 30, 2016

Total Enrollment: 14,374

A total of 14,374 participants were enrolled in Healthy San Francisco as of September 30, 2016.

City Option Program Enrollment as of July 2016

Employers can choose to meet the employer spending requirement of the San Francisco Health Care Security Ordinance (HCSO) by participating in the City Option Program. Employees of participating employers may enroll in the Healthy San Francisco Program if they meet HSF eligibility requirements, or are provided a Medical Reimbursement Account (MRA) to pay for eligible health care expenses if they do not qualify for HSF.

City Option Program Data – September 2016

	Program-to-Date (PTD)	September 2016
Employers		
Employers Participating in City Option Program	2,912	
Employers with Contributions Within the Past 12 Months	n/a	1,828
New Participating Employers	n/a	11
Total City Option Program Contributions	$525.6M	$2.2M
Contributions Assigned to HSF	$137.1M	$0.25M
Contributions Assigned to MRA	$388.5M	$2M
Employees		
Employees Receiving City Option Employer Contributions	238,051	
Employees Enrolled in HSF	18,648	407
Number of Medical Reimbursement Accounts with Deposits	179,897	3,756
MRA Claims Paid	$195.1M	$5.4M
MRA Dollars Available	$172.8M	

"SF Covered MRA" Update: Program Launches November 1

The SF Covered MRA, a city-sponsored program, will open to eligible City Option employees beginning November 1 in coordination with the start of open enrollment in Covered California. SF Covered MRA will provide premium and cost sharing assistance to San Francisco residents that purchase health insurance through Covered California and whose employers contribute on their behalf through the City Option program. SFHP is the third-party administrator for the program.

Multiple teams within SFHP are working hard to get the program up and running by the November 1 deadline. This consists of dozens of major projects, including the building of an eligibility and enrollment system, reconfiguration of employer contribution rules and accounting systems, training and hiring of new customer service and enrollment staff, and creation of multiple employee and employer notices and program materials/updates. SFHP is pleased to be implementing this new program and proud of the work accomplished so far over a short timeline. We will continue to keep the Board informed of this exciting new program.

SFHP MEMBERSHIP UPDATE

The global membership for SFHP as of October 1, 2016 is 148,492 members. Overall, SFHP membership increased by 1.3% (1,875 members) from August 2016 to October 2016. The global membership increased by 3.1% (4,427 members) since October 2015. Global membership is 1.3% (2,015 members) below the membership goal for October. Medi-Cal membership increased by 1.6% (2,179 members) from August 2016 to October 2016 and increased by 4.6% (6,010members) since October 2015. SFHP retains 86.5% of Medi-Cal market share in San Francisco County. Medi-Cal membership is below goal by 1.4% (2,034 members). **Please see Attachment 1** for SFHP Membership and HSF Participant reports.

Medi-Cal Expansion Updates

SFHP remains compliant with the requirement mandated by AB 85 to default 75% of non-choosing M1, 7U and L1 aid code members to primary care providers within the public hospital system.

Month of Enrollment	L1 Aid Code (SF PATH transition members)	M1 Aid Code (Optional Expansion members)	7U Aid Code (CalFresh-related Optional Expansion members)	AB 85 Default Requirement to Public Hospital System (M1 and 7U only)
2016				
January	6 members	1,734 M1 members; 1,550 did not choose	8 7U members; 8 did not choose	1,170 members of 1,558 non-choosers (75%) were defaulted to DPH.
February	4 members	1,504 M1 members;	9 7U members; 9	1,004 members of 1,337

Month of Enrollment	L1 Aid Code (SF PATH transition members)	M1 Aid Code (Optional Expansion members)	7U Aid Code (CalFresh-related Optional Expansion members)	AB 85 Default Requirement to Public Hospital System (M1 and 7U only)
		1,328 did not choose	did not choose	non-choosers (75%) were defaulted to DPH.
March	1 member	1,735 M1 members; 1,453 did not choose	3 7U members; 3 did not choose	1,091 members of 1,456 non-choosers (75%) were defaulted to DPH.
April	3 members	2,084 M1 members; 1,812 did not choose	3 7U members; 3 did not choose	1,362 members of 1,815 non-choosers (75%) were defaulted to DPH.
May	3 members	1,560 M1 members; 1,381 did not choose	2 7U members; 2 did not choose	1,037 members of 1,383 non-choosers (75%) were defaulted to DPH.
June	2 members	1,569 M1 members; 1,347 did not choose	2 7U members; 2 did not choose	1,013 members of 1,349 non-choosers (75.1%) were defaulted to DPH.
July	2 members	1,762 M1 members; 1,541 did not choose	1 7U member; 1 did not choose	1,157 members of 1,542 non-choosers (75%) were defaulted to DPH.
August	2 members	1,518 M1 members; 1,256 did not choose	2 7U members; 2 did not choose	946 members of 1,258 non-choosers (75.2%) were defaulted to DPH
September	1 member	1,530 M1 members; 1,272 did not choose	1 7U member; 1 did not choose	956 members of 1,273 non-choosers (75.1%) were defaulted to DPH
October	1 member	1,552 M1 members; 1,340 did not choose	1 7U member; 1 did not choose	1,007 members of 1,342 non-choosers (75%) were defaulted to DPH

STRATEGIC ANCHOR 2: QUALITY CARE & ACCESS

HEALTH SERVICES UPDATE

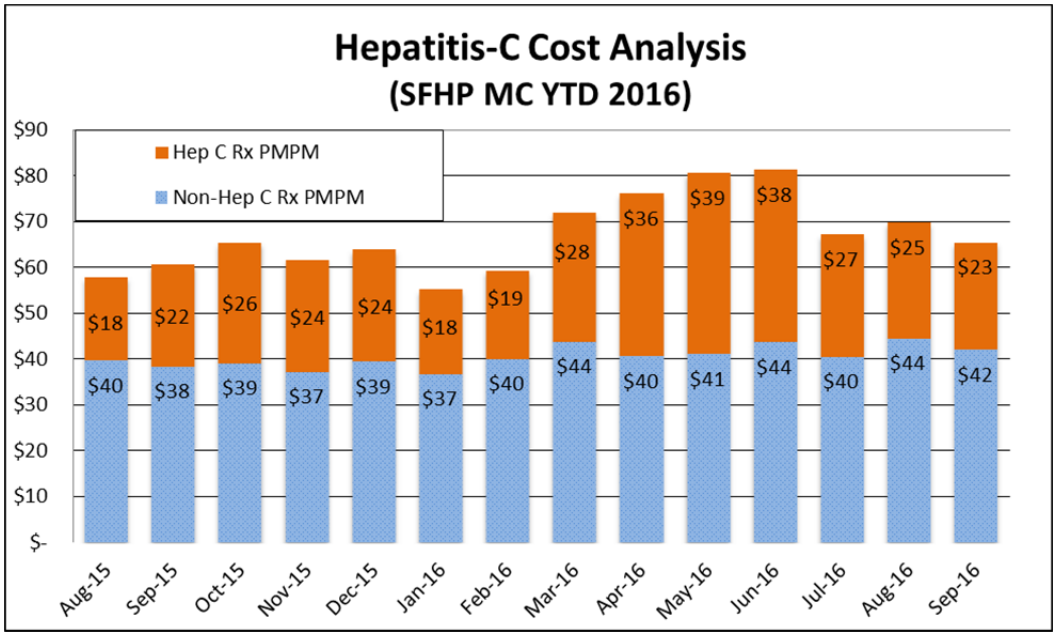
The following Health Services update provides key updates from Pharmacy, Health Outcomes Improvement, Clinical Operations and Care Management.

Pharmacy

Healthy Workers: Assuming management of the Healthy Worker pharmacy benefit effective December 1st required implementation work by all members of the pharmacy team, our pharmacy benefits management (PBM) vendor, PerformRx, along with ITS, Marketing, Customer Service, and Compliance teams. All tasks are on schedule and transition is expected to be seamless for the members. Benefit enhancements include a broader pharmacy network with 24 hour access, a broader formulary and removal of some prescriber restrictions.

Contract Amendment of PerformRx Agreement: Pharmacy completed a contract amendment with PerformRx to extend the contract to December 31, 2017 and include claims processing and other PBM services for the Healthy Worker membership. Per the Board-approved contracting policy, the contract was extended for one-year without the need for Board approval since it was within the five-year renewal period. This amendment also includes a settlement on performance guarantees related to claims pricing. This settlement will achieve approximately $1.51M in savings from SFHP's administrative payment to PerformRx. This settlement will be paid over a 12-month period ending December 31, 2017.

Pharmacy Trend Analysis: The significant increase in pharmacy costs observed in March and April was largely driven by Hepatitis C treatment with 'New Starts' increasing to 50 members in March/April (up from ~20 members starting Hepatitis C treatment in Dec/January). This increase is leveling off and is down since July as the newest medications, Epclusa and Zepatier, which are significantly less costly than Harvoni, are now the preferred Hepatitis C treatments for SFHP members.



Health Outcomes Improvement

Strategic Use of Reserves

The Access and Care Experience team is reviewing submitted applications for the Strategic Use of Reserve grant projects. The objective of this Board-approved initiative is to achieve significant improvement in access to services and to improve real-time data sharing for hospitals. SFHP expects to finalize all grant applications by November 2016.

Access Monitoring

The Access and Care Experience team is coordinating the Provider Appointment Availability Survey (PAAS) for 2016. The survey will be fielded until December 16, 2016 and measures patient access requirements. SFHP will summarize the results and share them with provider groups in April 2017 (a summary will be provided to the Board in May 2017). During the past several months, the Access and Care Experience team has worked in collaboration with the Provider Network Operations department to review and close corrective action plans from nine contracted groups and two independent providers regarding access and availability results from 2015.

HEDIS

SFHP held individual meetings with all medical groups to share plan- and group-level HEDIS results. Some data quality improvement opportunities were identified that SFHP looks forward to working collaboratively to explore. Internally, SFHP launched two HEDIS-related committees. The Clinical Oversight Committee will determine the SFHP Priority Measures each fiscal year and the Interventions Committee will propose and operationalize interventions for the SFHP Priority Measures. For fiscal year 2017-2018, the SFHP Priority Measures are as follows: Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Follow-up Care for Children Prescribed ADHD Medication, and Pharmacotherapy Management of COPD Exacerbation.

Practice Improvement Performance (PIP) Program

SFHP completed the first draft of the 2017 Primary Care Practice Improvement Program (PIP) guide and looks forward to Advisory Committee feedback at the October 20th meeting. Preliminary and final releases to the entire network are planned for November and December, respectively. The 2017 Specialty Care PIP guide will be finalized by November. The 2017 primary care program will see the addition of many new clinical measures to align with treatment guideline updates as well as external efforts such as PRIME. In the specialty care program, Third Next Available Appointment will be incentivized for more ZSFG specialties.

Care Management

DHCS announced that implementation of the Health Homes program, originally targeted for implementation by January 1, 2017, has been delayed to no sooner than July 1, 2017. DHCS is in the process of developing an implementation timeline and deliverables for the participating health plans. They have yet to communicate the per member per month rate to be paid to the health plans for administering the Health Homes benefit.

STRATEGIC ANCHOR 3: EXEMPLARY SERVICE

OPERATIONS UPDATE

Operations is comprised of the following departments: Claims, Customer Service, Member Eligibility Management (MEM), Performance and Process Improvement (composed of Business Solutions, Continuous Improvement, Enterprise Project Management, and Operational Risk and Analytics), Provider Network Operations (PNO) and Marketing and Communications. We continually strive to streamline processes to strengthen our core operations.

Below are updates from Operations on key initiatives:

- Operational metrics were met for September.
- Customer Service handled more than 12,000 City Option calls in the last two months and assisted San Francisco employees to register for their Medical Reimbursement Accounts so they would not lose their funds due to the change in the registration policy regarding terminating inactive accounts.
- Operations departments are actively involved and/or running the member and provider portals implementation, enhanced provider search tool, business continuity planning, Health Homes, and NCQA accreditation.
- The Provider Appreciation Dinner was held on Thursday, September 15th. Providers voiced their appreciation for SFHP holding this annual event and for acknowledging and recognizing the immense efforts of our valuable community providers. Below is a list of the awardees from this year's event:

Type of Award	Awardee / Title	Reason for Nomination
Excel and Lead	Kristina Hung, CNS Lactation Consultant @Zuckerberg-Chan San Francisco General Hospital Birth Center	Kristina embodies SFHP's mission and is a true patient advocate; she is committed to improving health outcomes for underserved moms and their newborn babies. Over the past year, she identified quality and supply issues with breast pumps being ordered for SFHP members that were prohibiting new moms from meeting their breastfeeding goals. Due to Kristina's hard work and advocacy, SFHP members discharged from SFGH in need of breast pumps are now receiving timely delivery of high-quality pumps that help ensure the healthiest start for their newborns.
Advocacy and for Pediatric Health	Lyra Ng, MD Pediatrician	SFHP honors Dr. Ng as an oral health champion within her practice and among her peers in San Francisco Chinese communities. She is a tireless advocate for fluoride varnish application and guidance to parents starting in infancy, which are invaluable tools to combat dental caries and the pain, costly treatment, nutritional problems, and problems with adult teeth that can follow. Her expertise and guidance provided to practices all over the community are very appreciated.
Superior Customer Care	Daniel's Pharmacy	Daniel's Pharmacy is taking the initiative to work with the Hepatitis C eradication effort and is assisting our members to ensure they are compliant with their therapy. They are a great example of how a pharmacy should work within their community and provide the best services to the best of their ability. They are always enthusiastic and a pleasure to work with. The services that they provide for our members can be a model for all pharmacies.

Type of Award	Awardee / Title	Reason for Nomination
Innovations and Collaboration	End Hep C SF	Hepatitis C has a major impact on the health of many San Francisco residents. New advances in therapy present a real opportunity to fight back. End Hep C SF aims to eliminate hepatitis C in San Francisco, and the initiative brings partners together from all over the San Francisco community to accomplish this goal. It is an ambitious project with the potential to save many lives, and we honor them for what is already accomplished, as much as for the important work ahead.
Diligence and Ingenuity in Case Management	Transgender Health Services	While San Francisco has been a leading community in trans* care for many years, access to medical and supportive care is an often-complicated process. Navigation and coordination of health insurance, providers, and treatment are essential to meet the needs of trans* clients. Transgender Health Services is an absolutely invaluable partner to SFHP as they help their clients along their challenging paths. Their research, advocacy, and expertise have shaped and continue to shape SFHP's work for trans* members to the benefit of all.
Patient Experience Excellence	Positive Health Program	SFHP congratulates the Positive Health Program for making great strides in patient experience throughout 2015. Using the Clinician and Group Consumer Assessment (CG CAHPS), the Positive Health Program improved their patients' ratings more than any other clinic with SFHP. We hope and trust in more success as their efforts continue through 2016.
Excellence in Ancillary Care	City Wheelchairs	SFHP commends City Wheelchairs for their outstanding service and collaboration, as well as their impressive record of maintaining the best follow-through practices and successful service recovery. City Wheelchairs has demonstrated not only their efficiency in collaborating care with SFHP, but also their enthusiasm and willingness to improve the lives and accessibility of our members.

STRATEGIC ANCHOR 4: FINANCIAL VIABILITY

BUSINESS CONTINUITY PLAN

SFHP's business continuity plan (BCP) is a document designed to prepare SFHP staff to successfully manage operations during business interruptions or disaster situations that may impact our ability to work from our offices, such as a power outage, earthquake or fire. SFHP's BCP serves as a reference tool to assist SFHP regain critical functions needed to maintain services to members and providers. The BCP identifies the necessary SFHP personnel and resources that ensure the timely restoration and continuation of services to SFHP's provider network and more than 148,000 members, as well as to regulatory agencies and vendors. SFHP's BCP will help to ensure SFHP will be prepared to handle unexpected disruptions.

SFHP staff members throughout the organization have been designated as Critical Functions Team (CFT) members. CFT members have identified key functions in their departments that must be prioritized to enable the resumption of operations during a business disruption. Critical functions staff have been identified to ensure resources are prepared and available during a business interruption or disaster. The CFT has been

preparing by participating in quarterly Tabletop Walkthroughs. Tabletop Walkthroughs are simulated business interruptions or disasters – such as an earthquake or fire – that the CFT talks through as a group to determine what steps are needed in order to resume critical functions in their functional area.

The BCP outlines how SFHP will resume power, obtain temporary work space, regain connectivity to business systems, and how to mobilize its CFT staff to resume critical functions. The BCP also addresses how to maintain communications with non-CFT staff during the business disruption. The BCP planning team is using the Tabletop Walkthroughs to make changes to the BCP, as well as to improve future mock disaster planning exercises. Regular maintenance and testing of the BCP through Tabletop Walkthroughs and other staff trainings is our proactive approach to preparing for unpredictable, yet inevitable, business interruptions and disasters.

INFORMATION TECHNOLOGY SERVICES (ITS) UPDATE

Analytic Data Warehouse (ADW)

As one of our Board-approved strategic goals for FY 16-17 and beyond, SFHP will be developing its future data strategy with a Member 360 data warehouse for analytic and decision support purposes. SFHP will be issuing an RFP with assistance from a consultant and KloudData, a vendor with data warehouse expertise in the Medi-Cal market and was recommended by one of our sister plans. The consultants interviewed over 30 SFHP staff and management team members to gather the business requirements. The ADW Team issued the RFP to 11 potential vendors on October 17th. Based on the business requirements gathered, at the conclusion of the ADW project (estimated to be 3 years), SFHP would like to achieve the following goals:

1. Establish a Strategic roadmap which will guide SFHP in the future development, maintenance and support of the ADW.
2. ADW data model should have the following features:
    a. Flexible dimensional model which would allow for the addition of new data domains without an overhaul of the existing design;
    b. Design should be agnostic of any particular business intelligence (BI) tool which would allow SFHP to adopt new BI tool(s) with ease;
    c. Member360 analysis covering all member related data sets ranging from Claims/Encounters and Eligibility to Lab Results and clinical data (EMR) amongst other data domains which would enable SFHP to perform population health and member outcome analysis;
    d. Provider360 should provide details on provider utilization, compare against peers and benchmarks, affiliation and provider specialty as well as other key provider identifiers. Prepare regulatory filing with ease, e.g. Rate Development Template;
    e. Support the development of Reinsurance rates;
    f. Trending on HEDIS and other quality measures; and

g. Provide required data to a Contract Scenario Modeling application to simulate various contractual scenarios such as Fee-for-Service and Capitation Carve Out.

3. ADW should be designed to capture data at various levels of granularity e.g. Detail, Episode-Group and Member-Month. Data at higher levels of granularity should have flags for standard classification.
4. Include data dictionary and standardized definitions e.g., Inpatient/Outpatient/ER visit, grouping of CPT codes, Therapeutic groups, DRG.
5. Enable creation of an Executive dashboard(s) with drill-down capabilities.
6. Include self service capabilities to perform ad hoc analysis.

The RFP Project Team, currently, is projected to select the final ADW implementation vendor by mid-December and present the recommendation for a vendor at the January Board meeting. It is the project team's goal to conclude the contract negotiation by the end of February and kick off implementation by March 15, 2017. Below is a projected high-level timeline:

Milestone	**Due Date**
ADW Implementation RFP:	10/17/2016 – 03/15/17
RFP Issued	10/17/2016
Questions/Inquiries Due	10/24/2016 12:00 PM PST
Publish Responses to Questions	10/27/2016
Proposals Due	11/07/2016 11:00 AM PST
Interview/Demo Invites Sent to Shortlisted Vendors	11/15/2016
Vendor Interview/Presentation Week	11/28/2016 – 12/02/2016
Final Vendor Shortlist	12/09/2016
Board Approval	01/04/17
Vendor Contract Negotiation	01/05/17 – 02/28/17
Contract Completion	03/01/2017
ADW Implementation:	03/15/17 – 06/30/20
ADW Project Kick-off	Prior to 03/15/2017
ADW Phase 0 – ADW Pre-Planning	03/15/17 – 06/30/17
ADW Phase 1 – Core Data Domains	07/01/17 – 06/30/18
ADW Phase 2 – Enhanced Data Domains	07/01/18 – 06/30/19
ADW Phase 3 – Advanced Analytics	07/01/19 – 06/30/20

Encounter Modernization/Quality Measures for. Encounter Data (QMED)

SFHP continues to send in quality encounter submissions on a bi-weekly basis to DHCS and targets a High Performing quarterly score. Since the last board update, the following activities

1. Beacon Non-specialty Mental Health Encounters: Due to changes in Beacon staffing, SFHP encountered additional delays in receiving encounter data from Beacon. As of today, Beacon is in the process of testing their 837P file with SFHP. DHCS is aware of the challenges causing this data gap.
2. QMED Dashboard: Completed internal QMED Dashboard which allows SFHP to proactively monitor our QMED score quarter-to-date in order to determine any needed timely remediation to maintain our High Performing status. Based on our internal QMED Dashboard, SFHP is showing High Performing for 2016 Q3. Note that SFHP received our QMED 2016 Q1 scorecard in August and it was High Performing as confirmed by our QMED Dashboard.

Notes on QMED Impact to Auto Assignment

- If Anthem Blue Cross (ABC) gets a High Performing Grade as well, 3% of auto assignment goes to SFHP and 3% goes to ABC
- If Anthem Blue Cross gets a Low Performing or Non-Compliant grade, then SFHP gets the entire 6%
- If both SFHP and ABC gets a Low Performing or Non-Compliant grade, then auto assignment is determined based on the original algorithm.

MEDIA ROUNDUP

Please see **Attachment 2** for the Media Roundup with articles related to Medi-Cal, Medi-Cal for All Children, Zuckerberg San Francisco General Hospital, provider directories, and telemedicine.

SFHP GOVERNING BOARD UPDATES

We are pleased to report that both Maria Luz Torre, Co-Chair of the Member Advisory Committee (MAC), and Eddie Chan, Pharm.D., CEO, North East Medical Services (NEMS) were approved for reappointment to the SFHP Governing Board by the San Francisco Board of Supervisors Rules Committee. A vote of the full Board of Supervisors will be held on October 25th. We look forward to their reappointment to our Governing Board.